



Queensland Government

Pulmonary Rehabilitation Referral Form

Please see reverse for contraindications

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: M F I

Please complete ALL sections
INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED

REQUEST TO: Dr (Respiratory Physician)

REQUESTING DOCTOR

Date of request: ____ / ____ / ____

Requesting Medical Officer: Team/Specialty:

Signature: Provider no:

Contact no: Fax OR email:

Diagnosis:

Problem list:

Purpose of referral:

Lung Function: FEV₁/ FVC FEV₁ (% of predicted)

Relevant past medical history

Cardiac disease (specify extent):

Peripheral Vascular Disease (specify extent):

Diabetes: Type 1 DM Type 2 DM Hypertension

Other (please specify):

Cardiac medications (please list):

Respiratory:

Beta Agonist ICS Oral steroid LAMA LABA Anti cholinergic

Other (specify):

Oxygen / Flow rate: Hours per day:

Walking Aids/ Mobility

Specify concerns:

Return to:

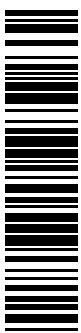
- SCUH Central Referral Fax 07 520 20555
- Send by secure web transfer using hospital template

Clients preferred venue:

Caloundra Gympie Nambour

DO NOT WRITE IN THIS BINDING MARGIN

2019/04 V3



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PULMONARY REHABILITATION REFERRAL FORM

INFORMATION FOR YOUR DOCTOR

Guidelines for Referral

Absolute contraindications:

- > Unstable angina in recent months
- > Recent myocardial event
- > Critical aortic stenosis
- > Cognitive impairment not suited to group work

Relative contraindications

- > Tachycardiac, arrhythmia
- > Severe hypertension systolic > 180
- > Severe mobility problems
- > PVD with claudication

Other considerations

- > Review locomotor skills – spinal and joint disease may impede benefits of program
- > Clients with oxygen and stable medical conditions are eligible for consideration
- > Must have ability or access to transport to nominated venue 2 times a week for 8 weeks.

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