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| **PULMONARY REHABILITATION REFERRAL** |
| Name: | DOB: |
| Address: | Phone:Mobile: |
| Respiratory Diagnosis: |
| Other Medical Conditions: |
| Relevant Investigations (e.g. CXR, LFTs, ABGs, other): |
| Medications: |

Have you discussed pulmonary rehabilitation with patient? Yes No

Will transport be required? Yes No

Patient’s funding status: Public DVA Private Worker’s Comp

 Other. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Health Professional**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_