Room 7-409, East Wing
399-Bathhurst Street
Toronto ,Ontario
M5T 2S8
Tel: (416) 603-5890
Fax: (416) 603-5854

REFERRAL TO PULMONARY REHABILITATION CLINIC

Date:_____ **MRN# :**_____

Client Name: _____ **DOB :**_____

Phone Number: Home # _____ **Business #** _____

Referring Physician :_____

Family Physician :_____

Diagnosis:
_____

Reason for Referral :
_____

_____

We provide an intensive approach to pulmonary health, assessment, medical management, diagnosis, treatment, education and cardiovascular fitness directed at lifestyle modification for clients with chronic lung disease.

Please indicate below your client needs:

_____ **Medication Regime and Compliance / Disease Process**
_____ **Lifestyle Management**
_____ **Smoking Cessation**
_____ **Nutritional Counseling**
_____ **Individualized Exercise Training and Reconditioning**
_____ **Energy Conservation Techniques**
Other _____

We require the following information:

Most recent PFT, Chest X- ray, 12 lead ECG , Blood Work and Medical History
Any questions, do not hesitate to call us at 603-5890

Physician Signature_____