



Caring
for my
COPD



Funding support provided by:



Patient Referral

Check box for referring hospital site:

- ☐ **1** Niagara Health System – Welland
- ☐ **2** Niagara Health System – Niagara Falls
- ☐ **3** Niagara Health System – St. Catharines
- ☐ **4** Other: _____

Contact Information

Caring for My COPD Program

Welland

Centre de santé communautaire

Tel: 905-714-9935 ext. 2285

Toll-Free: 1-866-885-5947

Fax: 905-714-1088

Niagara Falls

Community Health Centre

Tel: 905-356-6666

Fax: 905-356-6669

Patient Information

Surname		Given Name		Date of Referral		yyyy	mm	dd
Address				City		Postal Code		
Tel (Home)		Tel (Work)		Date of Birth		yyyy	mm	dd
OHIP #		Version Code		Service Preferred in		Translator Language Needed		
				<input type="checkbox"/> English <input type="checkbox"/> French				
Primary Contact	Name			Tel		Relationship		
Referring Physician/NP	Name		Address		Tel		Fax	
Family Physician	Name		Address		Tel		Fax	
Respirologist	Name		Address		Tel		Fax	

On oxygen (O₂)?

- ☐ Yes ☐ No
- O₂ Amount: _____

On CPAP or BIPAP?

- ☐ Yes ☐ No

Nebulizers?

- ☐ Yes ☐ No

Spirometry

yyyy	mm	dd
FEV1 _____ L _____ % predicted		
FVC _____ L _____ % predicted		
FEV1/FVC = _____		

Walking Oximetry

Test Date		yyyy	mm	dd
Lowest SpO ₂		On room air		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Distance walked				

- ☐ Patient is medically stable to enter the HNHB MY COPD Program exercise
- ☐ If not medically stable patient is able to attend education components only
- ☐ Patient has consented to be contacted regarding this program

Printed Name of Physician/NP/Delegate	Signature of Physician/NP/Delegate	CPSO#	Date (yyyy/mm/dd)
	X		
Printed Name of Referring Physician/NP/Delegate	Signature of Referring Physician/NP/Delegate	CPSO#	Date (yyyy/mm/dd)
	X		