Lakeridge Health Ambulatory Rehabilitation Centres

Respiratory Rehabilitation Clinic
Whitby Hospital
300 Gordon St., Whitby, ON L1N 5T2
Tel: 905−668−6831 ext 53091
Fax: 905−665−2416

This form must be completed and signed by a Physician or Nurse Practitioner.
Your signature below:

Acknowledges that you have assessed the referred client and confirm that s/he is safe to exercise in our rehabilitation program. Participants must be able to participate independently. We cannot accept patients who are clinically unstable, have unmanaged infectious disease, significant cognitive disorders, or reside in a LTC setting.

Is this patient currently a Lakeridge Health Inpatient? ☐ No ☐ Yes Unit _____ E.D.D. _____

Complete all sections of the referral and attach all related consultations			
First Name:	Last Name:		M ☐ F ☐
Address:	City:	Province:	Postal Code:
Phone Number:	Alternate Number:		
Health Card Number:		Date of Birth:	
Family Physician:	Phone:	Fax:	Allergies:
Medical History (check all that apply)			
☐ COPD	☐ Listed for lung transplant		☐ Bronchiectasis
☐ Interstitial Lung Disease	☐ Chronic Asthma		☐ Other lung condition
☐ Pulmonary Fibrosis	☐ Other		☐ Cardiac disease
Smoking History			
☐ Currently Smoking Cigarettes	☐ Quit	☐ In process of cessation	
☐ Other Inhaled Substances	☐ Cannabis ☐ Vaping	☐ E−Cigarettes	☐ Other
Home Oxygen			
Rest_____ L/min	Exertion:_____ L/min		☐ No current prescription
Infection Prevention			
Antibiotic Resistant Organisms:	Positive? ☐ No ☐ Yes	If **yes**, please indicate ☐ VRE ☐ MRSA ☐ CRE	
	Exposure? ☐ No ☐ Yes	If **yes**, please indicate ☐ VRE ☐ MRSA ☐ CRE	
Current Medications (including respiratory medicines and beta−blockers). Attach list.			
Drug Name / Dose / Frequency			
Physician/Nurse Practitioner's Name **(print)**		Physician/Nurse Practitioner's **Signature**	
Billing Number:		Date:	
Office Phone number:		Office Fax number:	

Fax completed form to (905) 665−2416