Richmond Community Respiratory Program Referral Form

For Internal Use Only:
PARIS#
Date Received:

Please complete form and fax to 236-454-1097
Call 604-369-7941 with any questions

Patient Information: PDF of form at https://vch.eduhealth.ca/PDFs/FN/FN.200.R531.pdf

Last Name: _____ First Name: _____ Initial:_____

Address: _____ Province: _____ Postal Code: _____

City: _____ Lives Alone: ☐ Yes ☐ No

Telephone No.(Home):_____ (Cell): _____

PHN: _____ DOB: _____/___ /___

Gender: Male Female yyyy mm dd

Main Language: _____ **Interpreter Required:** ☐ Yes ☐ No

Family Physician:	**Respirologist:**
Phone: Fax:	Phone: Fax:

Diagnosis: ☐ **COPD** ☐ **Asthma** ☐ **Other:**_____

☐ **Client aware of referral** ☐ **Diagnosis Confirmed**

Respiratory Medications:

Relevant History:

Any history of: ☐ Cardiac disease ☐ Neurological deficits ☐ Arthritis

☐ Allergies:_____ ☐ Others_____

Referring Physician:

Does your patient have any pre-existing health condition that would make exercise **unsafe**?

No ☐ Yes ☐ Specify: _____

Name: _____ Profession (**if not** a Physician): _____

Signature: _____ Date: _____

Attach following test results if available:

- ☐ **Pulmonary function test and/or spirometry test**
- ☐ **Exercise oximetry/6 minute walk test**
- ☐ **ECG**
- ☐ **Cardiac exercise stress test** ***if history of cardiac problems or abnormal ECG***

Classes are held at Garratt Wellness Centre
7504 Chelsea Place Richmond, BC