

Lung Health Program

Referral Form

Fax: 250-851-7965

Phone: 250-851-7954

Kamloops Downtown Health Centre #36-450 Lansdowne Street

Patient Name: _____

Address: _____

Postal Code: _____ Phone #: _____

Date of Birth: _____ PHN: _____

Family Physician: _____ Specialist: _____

Which Program?

Chronic Respiratory Rehabilitation Program

10 Classes (over 5 weeks) of exercise and education

Can this participant be involved in a graded exercise program? Yes No

COPD Assessment Individual education session/med review/spirometry

Asthma Education Adult Pediatric

Individual education session, spirometry and follow-up

Tobacco Cessation Counselling (NIC)

Current Diagnosis:

1. _____

2. _____

Current Medications:

1. _____ 3. _____

2. _____ 4. _____

Reason for Referral & Comments: _____

Referred By: _____ Date: _____

*Please inform your patient that he/she will be contacted to arrange an initial assessment appointment