Bancroft Community Family Health Team
19 Oak Street
Bancroft, ON K0L 1C0
Phone: 613-332-1565
Fax: 613-332-5541

Bancroft Community Family Health Team
North Hastings
Pulmonary Rehabilitation

Patient Name	
Date of Birth (D/M/Y) **Health Card #**	**Telephone** **Cell:** **Home/Work:** **Address**
Diagnosis	**Date of Onset** **Last Admission Date**

Has the client consulted with a Respirologist for this problem? Yes No
Specialist:
Date last seen:

Health History/Precautions:

Arthritis	Diabetes	Liver Disease	Other:
Arrhythmia	Dyslipidemia	Renal	
Allergies	Epilepsy	Other Neurological	
Cancer:_____	Heart Disease	Stroke / TIA	
COPD / Asthma	Dementia	Hypertension	

Please note any cardiac diagnosis/history this patient may have:

_____

Does your patient currently use home Oxygen? No Yes: _____ lpm at rest
_____ lpm activity/exercise
_____lpm during sleep

Please include the following test results if completed within the past 6 months:

Spirometry ☐ Included
Cardiopulmonary ☐ Included
Exercise Testing ☐ Included

Physician Name (please print)	**Signature of Referring Physician**
Physician's Telephone #	**Date**

Please ensure that the referral is fully completed and supporting documents are attached before faxing.

Please fax referral to 613-332-5541