



**COPD Management Program
& Pulmonary Rehabilitation
Referral Form**

Please affix patient label

URN:

Family Name:

Given Names:

Address:

Date of Birth: / /

Sex: M F

Physiotherapy Department Outpatients

Bundaberg Hospital
PO Box 34 Bundaberg Q 4670

Phone: 07 4150 2550

Fax: 07 4150 2579

Email: WideBay-COPD-Program@health.qld.gov.au

Note: Due to demand for Public Physiotherapy services, the department operates waiting lists for all outpatient services. Appointments are offered according to clinical need and urgency. Clinical urgency for your patient is determined by the information you provide to the department on your written referral.

All referrals remain current for 12 months

Bundaberg Hospital:

- COPD Chronic Disease Management Program
- COPD Pulmonary Rehabilitation

Medical clearance for exercise participation:

An individualised exercise program may be recommended. Patients who would not be suitable for participation in exercise would include those with:

- Musculoskeletal or neurological disorders that prevent gentle exercise.
- Unstable cardiovascular disease (e.g. unstable angina, aortic valve disease, unstable pulmonary hypertension, NYHA IV heart failure).
- Known metastatic cancer.
- Have significant cognitive impairment or psychotic disturbance.
- Have a relevant infectious disease.
- Untreated acute illness.
- Uncontrolled Hypertension (Systolic >160 mm Hg, Diastolic >100 mm Hg)
- Resting oximetry (SpO2) <88% on room air or prescribed supplemental oxygen therapy

As of this date, I have reviewed my patient and am not aware of any health issues that would affect their participation in exercise. I provide medical clearance for exercise participation.

Clinical Urgency:

Non-Urgent Urgent – Please provide reason/s: _____

Clinical Diagnosis:

Medical History / Active medical conditions:

Specific Orders, Requests or Precautions:

Please attach a current medication list, any recent lung function test results and relevant investigations

Signature		Designation		Date	
Print Name		Contact Number			
Referral Initiated From	<input type="checkbox"/> Ward / Dept _____	Consultant			
	<input type="checkbox"/> SOPD Clinic _____	Consultant			
	<input type="checkbox"/> GP _____	Practice			

DO NOT WRITE IN BINDING MARGIN