



# Queensland Government

**Queensland Health**  
 Wide Bay Health Service District  
**COPD Program & Pulmonary Rehabilitation**  
 Main block Level 1 Bundaberg Hospital  
 PO Box 34 Bundaberg Q 4670  
 Phone: 07 4150 2550  
 Fax: 07 4150 2579  
 Email: [WideBay-COPD-Program@health.qld.gov.au](mailto:WideBay-COPD-Program@health.qld.gov.au)

Please affix patient label

Name:

Address:

Telephone:

Date of Birth: / /

Sex:  M  F

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 including Pulmonary Rehabilitation

**Medical clearance for exercise participation:**

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.

Patients not suitable for exercise participation would include those with:

- Unstable cardiovascular disease (e.g. unstable angina, aortic valve disease, unstable pulmonary hypertension, NYHA IV heart failure, uncontrolled arrhythmia).
- Myocardial infarction or unstable angina in the previous month.
- Uncontrolled Hypertension (Systolic >160 mm Hg +/- Diastolic >100 mm Hg)
- Resting pulse oximetry (SpO2) <88% on room air or while breathing prescribed supplemental oxygen therapy
- Significant musculoskeletal or neurological disability that prevents safe performance of exercise.
- Significant cognitive impairment or psychotic disturbance.

**Clinical Urgency:**

Non-Urgent  Urgent – Please provide reason/s: \_\_\_\_\_

**Respiratory Diagnosis:**

**Concurrent Medical History / Active medical conditions:**

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

|            |  |                |  |      |  |
|------------|--|----------------|--|------|--|
| Signature  |  | Designation    |  | Date |  |
| Print Name |  | Contact number |  |      |  |

QH Ward / Dept                      Consultant:

GP    Practice:

DO NOT WRITE IN BINDING MARGIN