



Pulmonary Rehabilitation Referral Form (LungMax®)

Please see reverse side for contraindications

PATIENT ID LABEL

Patient's Name:
 DOB:
 Address:
 Postcode:
 Patient Contact No:

Date of referral
 Consultant: Dr
 Referring DR: Dr
 Address:
 Referring Dr's Signature:

Diagnosis

Problem List

Purpose of Referral

Lung Function

FEV₁ / FVC

FEV₁ (% of predicted)

Relevant Past Medical History

- Cardiac Disease (specify extent)
- Peripheral Vascular Disease (specify extent)
- Diabetes Type 1 IDDM Type 2 NIDDM Hypertension
- Other (please specify)

Cardiac Medications

Please list

Respiratory

- Beta Agonist Spiriva or Atrovent ICS Oral Steroid
- Other (specify)
- Oxygen / Flow Rate Hours per day

Walking Aids / Mobility

Specify Concerns

Please fax or post to LungMax® C/o: **Respiratory Service**
PO Box 547
Nambour QLD 4560

Fax: 5470 6091 Tel: 5470 6768

Clients preferred LungMax® venue: Caloundra Nambour Noosa

INFORMATION FOR YOUR DOCTOR

For referral to LungMax[®] (Pulmonary Rehabilitation Program) use this form. Further copies or information can be obtained by contacting the CNC Respiratory SCWBHSD on 5470 6768.

Guidelines For Referral

Absolute Contraindications

- Unstable angina in recent months
- Recent myocardial event
- Critical aortic stenosis
- Cognitive impairment not suited to group work

Relative Contraindications

- Tachycardiac, arrhythmia
- Severe hypertension systolic > 180
- Severe mobility problems
- PVD with claudication

Other Considerations

- Review locomotor skills – spinal & joint disease may impede benefits of program
- Withhold program for clients in an acute exacerbation (4 -6 weeks post hospital discharge)
- Clients with oxygen and stable medical conditions are eligible for consideration
- Must have ability or access to transport to nominated venue 2 times a week for 8 weeks. Consider HACC funding assistance for transport.
- Program runs continuously throughout the year with a short break over Christmas/ New Year period.