Tel: 905 523 6611 x 3060
FAX: 905 667 8859
Toll free: 1 877 361 3338

Program Referral

Location: North Hamilton Community Health Centre, 438 Hughson St. N., Hamilton, ON

REFERRAL DATE: ____ ____ ____ M D Y	DATE OF BIRTH: ____ ____ ____ M D Y	GENDER:	OHIP#
SURNAME:	FIRST NAME:		TELEPHONE:
ADDRESS:	CITY:		POSTAL CODE:

REFERRING PHYSICIAN / NP	**NAME:**	**ADDRESS:**
	TELEPHONE#:	**FAX#:**

PRIMARY CARE PROVIDER If different from above	TEL:	FAX:	ADDRESS:

SPIROMETY

FEV$_1$: L %	**FVC:** L %	**FEV$_1$/FVC ratio**	Date:

NOTE: The FEV1/FVC must be < 0.7

OXYGEN:	**L/min**	**SMOKER:**	☐ **YES** **OR** ☐ **NO**

PHYSICIAN or NP's CLEARANCE TO PARTICIPATE IN PHYSICAL ACTIVITY STREAM

To ensure client safety for graded levels of exercise, please indicate below if client is **medically stable and cleared to participate in mild/moderate physical activity** (based on self perception of exertion).

☐ Client is **medically stable** and can **participate in exercise and education**

☐ Client is **NOT medically stable** and should participate in / attend **education only**

Physician / Nurse Practitioner Signature / Delegate:

***Fax signed and completed form to*: FAX: 905 667 8859**

***PLEASE ATTACH PATIENT EMR SUMMARY AND SPIROMETRY REPORT IF AVAILABLE ***

Referral will be triaged and INCOMPLETE referrals will be returned.
Client will be contacted for participation once completed referral is received.