

COMMUNITY RESPIRATORY REHABILITATION HAMILTON - CLIENT REFERRAL

Fax: (07) 838 0852 Ph: (07) 838 0851 Email: asthmawaikatotracy@xtra.co.nz Healthlink EDI ATHMWAI

Referred by: _____ Date: _____

CLIENT INFORMATION

Surname: _____ First Names: _____

Address: _____

Home/Work Phone: _____

Mobile: _____ Email: _____

DOB: _____ Gender: M / F (Please circle one)

GP: _____

Ethnicity: _____ NHI No: _____

Waikato PHO client: Yes / No (Please circle one)

Smoking status: smoker /non-smoker /passive smoker /never smoked (Please circle one)

Primary Diagnosis: COPD Yes / No (Please circle one)

Medical clearance is required for your patient to undertake the physical assessment (six minute walk test) and the exercise component of this Community based Respiratory Rehabilitation Program. We also need his/her relevant medical history. Please note the eligibility criteria on the attached Fact Sheet before giving your consent.

Medical clearance

I, _____ hereby provide medical clearance for my patient, _____
(Dr's Name) (Patient's full name)

to undertake a six minute walk test for the Community Respiratory Rehabilitation Programme and to participate in the physiotherapist-led exercise component of the program.

Signed: _____ Date: _____

Please fax or email this referral form and additional client information to Asthma Waikato

All referrals need to include the following:

- ☐ (This) Asthma Waikato Client Referral form
- ☐ Spirometry result (recent—12 months)
- ☐ ECG if there is a risk of cardiac complications (recent—1 month)
- ☐ Client's other relevant health conditions and current medications

✓ Please tick to confirm all data is attached

This information MUST be provided in order for your client to be accepted onto this program.

Asthma Waikato is accepting referrals for the Hamilton Programme from now until

Monday 31st January 2011