Hawkesbury District Health Service

Pulmonary Rehabilitation CALM Program

MRN NO:________________
SURNAME:________________
GIVEN NAMES:________________
DATE OF BIRTH:________________SEX:__________
ADDRESS:________________
(SJOG USE ONLY - AFFIX LABEL HERE)

Referral Date:	
Name:	
Date of Birth:	
Address:	
Phone:	
Alternative Contact:	
□ Interpreter needed:	**Language:**

Reason for Referral:

Respiratory Diagnosis and summary of last 12 months of respiratory history (including exacerbations, admissions to hospital and referral to other respiratory services).

Relevant Medical History:

Medications:

Smoker: Yes □ No □ Previously smoked □

Relevant Investigation Results:

CXR:

Spirometry: FEV[1] / FVC **[Predicted FEV1/FVC]**

SpO2:

Home O2 Yes □ No □	**Flow Rate:** **Hours/ Day:**

Please attach: Respiratory Action Plan □ GP Management Plan □ Current Health Assessment □

Referring Doctor Name:	**Contact No:**
Address:	
Referring Doctor Signature:	**Provider Number:**

Referral Fax to Hawkesbury District Community Health Service: 02 4560 5713