Pulmonary Rehabilitation – GP Referral Assessment Form

Patient's name:
DOB:
Address:
Phone no:
Medicare no:

The following medical assessment will need to be completed prior to your patient being accepted to the pulmonary rehabilitation program.

	Yes/No	Details
History of Cardiac Condition		
Angina		
Hypertension		
Other cardiovascular condition – specify		
Musculoskeletal problems (limiting exercise)		
Obstructive lung disease		
Restrictive lung disease		
Reversible lung disease		
Needs an interpreter		
Able to understand and follow instructions		
Cancer		
Neuromuscular disease		
Recent stress test (date/results)		

Past History:

Current Rx:

Doctors Signature:_____

Name: _____ Date:_____

Bowral & District Hospital – Pulmonary Rehabilitation
Fax: 02 4861 0251
Attention: Holly Pederson – Senior Physiotherapist