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Patient's Name: _____
First Initial Last

Phone # _____ Sex M F DOB: _____

Address: _____
Street # Street name City Postal Code

GP/FP: _____ Health Card : _____

Medication(s) (list):

Relevant Information: e.g. Diabetes, etc.

Group Session: _____

- Smoking Cessation
- Cognitive Assessment
- Chiropody
- Well Woman Clinic _____
(Date of last pap test)
- Mental Health _____
(Brief Details)

Diabetes Services—Requires relevant blood work ** PLEASE Attach Laboratory Results

- Pre-Diabetes Diabetes Education New Est. Insulin Start (complete insulin start order)

Dietitian Services—Requires relevant blood work ** PLEASE Attach Laboratory Results

- Cholesterol
- Weight
- GI Issues _____
(Brief Details)
- Child Nutrition Screening (18 mo to 6 yrs)
(Please attach growth chart incl. growth hx.)
- Other _____

Occupational Therapy: (Disclaimer: Patients currently receiving funding through WSIB or private insurance should have depleted those resources before being referred to the RFHT Occupational Therapist.)

- Balance and Strengthening Exercise Program
- Fall Prevention, Balance and Mobility Assessment
- Functional Assessment
- Fit to Drive Screen

COPD Program

- COPD Group Exercise/Education & Spirometry* (req'd for BODE index*)
- COPD Education Only
- Spirometry With Pre & Post Bronchodilator
(To confirm COPD diagnosis)
- Simple Spirometry (No Bronchodilator)
- Hold Meds: Yes No
- Postpone Spirometry: (Reasons): _____

Physician Consent: _____
(Physician signature)

Client Health Information:

- Confirmed COPD Confirmed Asthma diagnosis Suspected COPD d Suspected Asthma
- Client Currently on Oxygen @ _____ L/min, For Exercise @ _____ L/min
- Non Smoker Smoker
- Allergies: NKA or List: _____
- Current Inhalers (list): _____