Rapids
Family Health Team

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Revised: July 2015

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)* **Hold Meds: ☐Yes ☐ No**
☐ Simple Spirometry *(No Bronchodilator)*
☐ 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): _____