Queensland Government

Western Corridor Pulmonary Telerehabilitation Referral Form

Hospital & Health Service

(Affix identification label here)

URN: ☐
Family name: ☐
Given name(s): ☐
Address: ☐
Phone: ☐
Date of birth: ☐ Sex: ☐ M ☐ F ☐ I

DO NOT WRITE IN THIS BINDING MARGIN

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All clinical forms creation and amendments must be conducted through Health Information Unit

Date of Referral

Referral Client Age ☐ Under 65 years ☐ Over 65 years ☐ Identifies as First Nations People

Client Aware of Referral ☐ Yes ☐ No

Referrer Details
Name: ☐
Discipline: ☐
Phone: ☐

Patient's Nominated General Practitioner:
Name: ☐
Practice Name: ☐
Phone: ☐
Email: ☐

Pre Pulmonary Telerehabilitation Ax Status

Medical Clearance obtained ☐ Documented below	☐ Yes	☐ No	☐ Attached
Nursing Ax completed	☐ Yes	☐ No	☐ Attached
Falls Ax completed	☐ Yes	☐ No	☐ Attached
6 Minute Walk Test Completed	☐ Yes	☐ No	☐ Attached
Short Physical Performance Battery (SPPB) Completed	☐ Yes	☐ No	☐ Attached

Respiratory Diagnosis and Program request: *(include all relevant information on presenting acuity/severity; provisional clinical diagnosis, assessments, procedures or anthropomorphic measures to ensure correct triaging.*

Oxygen Required ? ☐

Co-morbidities:

Health Summary/Letter Attached ☐

Allergies / Adverse Reactions:

Current Medications

Medication List Attached ☐

Investigations and Spirometry:

Attached ☐

Submit this referral to the following email address: WC_telerehabilitation@health.qld.gov.au