COPD
Community Exercise Clinic

A community based program for people living with Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD)

COPD is a term used to describe emphysema and chronic bronchitis. Research has shown that regular exercise and effective self-management strategies can help maintain fitness and well-being as well as improve symptoms and quality of life.

COPD Community Exercise Clinic

For those living with Chronic Obstructive Pulmonary Disease, our community based program will help you gain better control of your COPD.

Physician Referral is required (see back)

Benefits of Participating

- Manage your COPD symptoms
- Improve fitness levels, energy, and endurance
- Reduce stress, anxiety, and depression
- Reduce illness and hospital admission

The **COPD Community Exercise Program Clinic** provides you with the skills you need to exercise safely, manage your breathlessness, to stay well and out of the hospital.

- Individual physical assessment and goal setting
- 12-week group education and exercise session (in person or virtual)
- Personalized exercise program
- Health and Self Management Education
- Connecting with community resources

Let us help you build your plan so you can continue enjoying the activities you love

Lakeridge Health

COPD
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This form must be completed and signed by a Nurse Practitioner or Physician

Your signature below indicates:

- A referral to our COPD Community Exercise Clinic.
- The physical assessment will include a 6MWT, Sit to Stand, mMRC Dyspnea Scale, CAT Score, results will be forwarded to your office and the consulting Respirologist.
- Acknowledges that you have assessed the referred client and confirm that s/he is safe to exercise in our rehabilitation program. Participants must be able to participate independently.
- We cannot accept patients who are: clinically unstable, have unmanaged infectious disease, significant cognitive disorders, or reside in a long term care setting.

Please complete all sections of the referral and attach all related consultations.			
First Name:		Last Name:	Phone:
Address:		City:	Alternate:
DOB:	M☐ F☐	Province:	Postal Code:
Family Physician:		Phone:	Fax:
Health Card Number:			
Medical History: please check all that apply			
COPD: ☐		Recent Hospitalization Date: _____	
All other lung conditions, refer to Respiratory Rehab at LHW ☐ (*bronchiectasis, Interstitial Lung Disease, Chronic Asthma, Pulmonary Fibrosis, Listed for Transplant)*			
Other: ☐			
Smoking History:			
Currently Smoking: ☐ Cig/day: ___		Quit Date: ☐ _____	Tobacco ☐ Vape ☐
Years Smoked: _____		In process of quitting: ☐	Cannabis ☐ Other ☐
Home Oxygen & Target Sp02:			
Rest _____/lpm Sp02:_____%		Exertion: _____/lpm Sp02: _____%	No current prescription: ☐
Current Medications (including respiratory medicines and beta-blockers). Attach list.			
Referring Physician/NP Name **(Please print)**		Physician/NP Signature	
Billing Number:		Date:	
Office Phone number:		Office Fax number:	

Please fax completed form to (905) 665-2416