iMasterHealth

Lung Workshop Patient Referral Form

Refer your patient to an 8-week virtual, home supervised exercise program!

Patient Information

Full Name: _____

Date of Birth (M/D/Y): _____

Phone Number: _____

Email: _____

Lung Diagnosis:

_____

Referring Healthcare Provider

Name: _____

Profession: _____

Clinic / Hospital: _____

Phone Number: _____

Email: _____

Fax: _____

FEV1: _____ **FVC:** _____ **Date performed** (if available): _____

Oxygen (if applicable) **at Rest:** _____L/min **on Exertion**: _____L/min

Co-morbidities (check all that apply):

- ○ Heart Disease
- ○ Hypertension
- ○ Diabetes
- ○ Stroke
- ○ Obesity
- ○ Cancer
- ○ Other: _____

Additional comments:

_____

_____

_____

To ensure patient safety for exercise, please indicate if patient is medically stable and cleared to participate in mild/moderate exercise.

- ○ Client **is medically stable** and **can participate in exercise**.
- ○ Client is **NOT** medically stable.

Signature: _____ **Referral Date:** _____

Please fax this form to **+1 315 204 1952** or email to **amanda.holyk@imasterhealth.com**

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