DOB _____	PID Number
Gender _____	PID
Title _____ Surname _____	
Given Names _____	
Address _____	
(Type if Affix Sticker)	

Chronic Obstructive Pulmonary Disease - Community Support Program - Referral Form

Eligibility Criteria:

Confirmed Diagnosis of COPD ☐ Public Patient in hospital ☐

Not currently on home oxygen ☐ Patient aware of referral ☐ Yes ☐ No

Interpreter required Y /N Language spoken: _____

Client Details

Name: _____

Address: _____

Date of Birth: _____

Phone No: _____

NOK Details: _____

Referrer Details	**GP Contact Details**
Address:	
Designation:	
Phone No:	

Medical History

Allergies:

Spirometry – Attach if available

FEV1: _____ FVC: _____ FEV1/FVC: _____

CPAP ☐ NIV ☐

COPD Action Plan attached ☐	Referred to Pulmonary Rehab ☐
Emergency Script provided ☐	Discharge Summary Attached ☐

Name: _____ **Signature:** _____ **Date:** _____

Fax to Silver Chain: 1300 601 788

For further information contact Silver Chain 9242 0242 Ask for the Respiratory Liaison Nurse

DO NOT WRITE IN THIS BINDING MARGIN

All clinical forms creation and amendments must be conducted through the documentation control process

Once PRINTED, this is an UNCONTROLLED DOCUMENT. Refer to the Policy Document Management System for latest version.