



**ST VINCENT'S  
HOSPITAL**  
SYDNEY

**Pulmonary Rehabilitation  
Breath Easy Referral Form**

MRN		SURNAME	
GIVEN NAME(S)			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

**BREATHE EASY INTERNAL / EXTERNAL REFERRAL FORM**

**Referring Professional:**

**Contact No.:**

**Date of Referral:**

**Designation:**

**Signature:**

**Exclusion:**

- Severe cognitive impairment or inability to learn
- Relevant infectious diseases
- Unstable* cardiac disease or pulmonary hypertension
- Psychotic disturbance
- Musculoskeletal disease, neurological, orthopaedic or cardiac disorders that prevent gentle exercise
- Wheelchair bound
- Metastatic cancer
- Severe hepatic dysfunction

**Diagnosis**

**Relevant Medical History** *(please attach patient's health care summary / care plan if available):*

**Current Medications:**

**Oxygen Therapy:**

Home oxygen:  Yes  No If Yes, L/min \_\_\_\_\_ hours/day \_\_\_\_\_

**\*Doctors Only:** Do you agree to the use of an appropriate level of supplemental oxygen if the patient desaturates during the exercise?  Yes  No

<b>Spirometry Date:</b>  _____		Measured	% Predicted
	<b>FEV<sub>1</sub></b>		
	<b>FVC</b>		
	<b>FEV<sub>1</sub> / FVC</b>		

**Please send this Form to the Pulmonary Rehabilitation Coordinator,  
Physiotherapy Department  
St Vincent's Public Hospital, 390 Victoria Street, Darlinghurst NSW 2010  
Fax: (02) 8382 3345 Ph: (02) 8382 3349  
Email: SVHS.PulmRehab@svha.org.au**

**BINDING MARGIN - NO WRITING**  
St Vincent's Hospital Sydney Limited  
ABN 77 054 038 872

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