IUIH Cardiac and Pulmonary Rehab Programs
Referral Form

<table>
<tr><td>Date of Referral:</td><td>Program referring to:
☐ Pulmonary Rehabilitation ☐ Cardiac Rehabilitation</td></tr>
<tr><td>Client's Full Name:</td><td>DOB:</td></tr>
<tr><td rowspan="2">Client's address:</td><td>Phone:</td></tr>
<tr><td>Alternate contact (optional):</td></tr>
<tr><td colspan="2">Identifies as:
☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander</td></tr>
<tr><td colspan="2">Diagnosis or Operative procedure relevant to referral:</td></tr>
<tr><td colspan="2">Recent hospital admission:
☐ No ☐ Yes Date of discharge: Reason:</td></tr>
<tr><td colspan="2">Discharge summary attached or written:
☐ No ☐ Yes</td></tr>
<tr><td colspan="2">Medical History and relevant symptoms attached or written:</td></tr>
<tr><td colspan="2">Medication attached or written:</td></tr>
<tr><td colspan="2">Results of specific investigations attached or written:
E.g. Resp: LFTs, ABGs Cardiac: ejection fraction, troponin, CK, dated and detailed</td></tr>
<tr><td colspan="2">Exercise Clearance: Is this client stable and safe to exercise.
☐ No ☐ Yes – independently / in a group setting ☐ Yes – with a carer or one-on-one support</td></tr>
<tr><td colspan="2">Client consent obtained for referral to rehabilitation program, for IUIH staff to access to relevant medical records, and contact client for access to the rehabilitation program.

Consent gained: ☐ Yes ☐ No</td></tr>
<tr><td>Prescriber, please share clients GP details if known so they can be included in all correspondence:

GP Name:</td><td>Prescriber details and with consent for IUIH staff to contact if requiring clarification of referral content.

Full Name:</td></tr>
<tr><td>Name of Medical Centre:</td><td>Profession:</td></tr>
<tr><td>Email or phone or address:</td><td>Email or phone contact:</td></tr>
</table>

Note: Client contact cannot be made until referral and consent is completed.

Send referral via:
Email: rehab@iuih.org.au