

Community COPD Program Referral

Please Fax Referral to: 902-569-0579 or email: COPDCoordinator@ihis.org

Referral Location: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department <input type="checkbox"/> Other: _____	Address: _____ Phone: _____ Family MD/NP: _____ Admission/ER Visit Date: _____ Alternate Contact: _____	Patient Label
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Declined Referral: YES Reason: _____

To assist with triage please answer the following questions:

1) Ask Patient “When you are home and feeling well, how would you rate your shortness of breath?”	2) Are <u>any</u> of the following INSPIRED eligibility criteria applicable?																		
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Grade</th> <th style="width: 90%;">Modified Medical Research Council (mMRC) DYSPNEA SCALE</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">0</td> <td>Breathless with strenuous exercise.</td> </tr> <tr> <td style="text-align: center;">1</td> <td>SOB when hurrying on the level or walking up a slight incline</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Slower than people of the same age on the level or stops for breath while walking at own pace on the level.</td> </tr> <tr> <td style="text-align: center;">3</td> <td>Stops for breath after walking 100 yards</td> </tr> <tr> <td style="text-align: center;">4</td> <td>Too breathless to leave the house or breathless when dressing</td> </tr> </tbody> </table>	Grade	Modified Medical Research Council (mMRC) DYSPNEA SCALE	0	Breathless with strenuous exercise.	1	SOB when hurrying on the level or walking up a slight incline	2	Slower than people of the same age on the level or stops for breath while walking at own pace on the level.	3	Stops for breath after walking 100 yards	4	Too breathless to leave the house or breathless when dressing	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center; vertical-align: top;"><input type="checkbox"/></td> <td style="padding: 5px;">Admission to hospital with Acute Exacerbation of COPD (AECOPD) more than once in the past year (this admission and at least one other)</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input type="checkbox"/></td> <td style="padding: 5px;">Admission to ICU due to AECOPD in past year</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input type="checkbox"/></td> <td style="padding: 5px;">Frequent use of ER services for AECOPD in the past year (with or without in-patient admission) (3 or more visits)</td> </tr> </table>	<input type="checkbox"/>	Admission to hospital with Acute Exacerbation of COPD (AECOPD) more than once in the past year (this admission and at least one other)	<input type="checkbox"/>	Admission to ICU due to AECOPD in past year	<input type="checkbox"/>	Frequent use of ER services for AECOPD in the past year (with or without in-patient admission) (3 or more visits)
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3) Post FEV ₁ /FVC _____ Post FEV ₁ (% Predicted) _____ Please complete Spirometry testing in Primary Care: _____ <div style="text-align: right;">(Physician/NP Signature)</div>																			
4) Lives in Long Term Care <input type="checkbox"/> Yes <input type="checkbox"/> No																			
5) Home oxygen <input type="checkbox"/> Yes <input type="checkbox"/> No Provider _____ O ₂ Prescription: _____ lpm																			

Additional Relevant Clinical Information: _____

COPD Medications: _____

Referral Source: _____ **Contact number:** _____

RT COPD Coordinator Use Only:		
Type of Follow Up: <input type="checkbox"/> Primary Care COPD Clinic	<input type="checkbox"/> Primary Care INSPIRED	<input type="checkbox"/> Home Care INSPIRED
Hospital Discharge Date: _____	Date last seen by PC/HC: _____	
48 hr phone call completed: _____	Home Visit Date: _____	
Alpha-1 Antitrypsin : _____	Baseline CO ₂ _____	Blood Eosinophils: _____ IgE _____ CAT Score _____