|  |  |
| --- | --- |
| **Eligibility Criteria:** referral within 1 month of discharge | |
| Confirmed Diagnosis of COPD | Public patient in hospital |
| Not currently on home oxygen | Patient aware of referral |

|  |
| --- |
| Interpreter required  Y  N Language spoken |

|  |  |
| --- | --- |
| **Client Details** | |
| Name: |  |
| Address: |  |
| Date of birth: |  |
| Phone No: |  |
| NOK details: |  |

| DOB |  | | | | PID Number |
| --- | --- | --- | --- | --- | --- |
| Gender |  | | | |  |
| Title |  | | | Surname |  |
| Given Names | | |  | | |
| Address | |  | | | |
|  | | *(Type or affix sticker)* | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Details** | | | |
|  | Doctor | Nurse | Physio |
| Address: |  |  |  |
| Designation: |  |  |  |
| Phone No: |  |  |  |

|  |
| --- |
| **Medical History** |
| **Medications** |
| **Allergies:** |

|  |  |  |
| --- | --- | --- |
| **Spirometry – attach if available** | | |
| FEV1: | FVC: | FEV1/FVC: |

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

|  |  |  |
| --- | --- | --- |
| Name: | Signature: | Date: |

|  |
| --- |
| **Please complete and fax individual referral to 1300 601 788 or email** [SCReferrals@silverchain.org.au](mailto:SCReferrals@silverchain.org.au) |
| For further information, speak to one our Silverchain Liaison Nurses on 1300 300 122 or contact Silverchain 9242 0242 |