NSW GOVERNMENT Health
South Eastern Sydney Local Health District

Pulmonary Rehabilitation Program Entry Form

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Client Name: _____ DOB: ____/____/_____
Address: _____ ☐ _____ ☐ _____
Country of Birth_____Language_____Interpreter Required_____
Aboriginal or Torres Strait Islander Yes ☐ ☐ No
Emergency Contact: Name: _____ Ph:_____
Relationship to Client: _____

Please select all/medical history that applies to this client

Lung Conditions	Heart Conditions	Other Conditions
☐ Asthma	☐ Cardiac Procedures	☐ Anxiety
☐ Bronchiectasis	☐ CABG ☐ Stent	☐ Arthritis
☐ Emphysema	☐ Angioplasty	☐ Depression
☐ Chronic Bronchitis	☐ Pacemaker ☐ AICD	☐ Diabetes (Insulin Y/N)
☐ Cystic Fibrosis	☐ IHD/ Angina	☐ Incontinence
☐ Pulmonary Fibrosis	☐ Previous MI	☐ Illiterate
☐ Interstitial Lung Disease	☐ Heart Failure (EF:_____%)	☐ Kidney Condition
☐ Lung Transplant	☐ AF	☐ Malnutrition
☐ Sleep Apnoea	☐ Stroke	☐ Musculoskeletal
		☐ Balance issues
☐ Steroid Dependent	☐ High Blood Pressure	☐ Obesity
☐ Has Home Oxygen	☐ Heart Valve Disease	☐ Osteoporosis
☐ C02 Retainer	☐ **Other/Comments:**	☐ Cognitively Impaired
☐ Smoking	_____	☐ Parkinson's Disease
☐ NIV	_____	☐ Vision Impaired
☐ Action Plan Y / N	☐ Action Plan Y / N	☐ Mobilises with Aids

Medications:_____
_____
_____

Patient has own means of transport ☐ Yes ☐ No Current walking distance_____
Is patient eager to participate ☐ Yes ☐ No

GP approval to participate in pulmonary rehabilitation ☐ Yes ☐ No
GP Name: _____**Ph:** _____
Address: _____
_____
Signature: _____ **Date:**_____

Please Fax To: 9113 3075

Developed October 2014. Based on the Illawarra Shoalhaven Local Health District and Lung Foundation "Lungs in Action Entry Form"

Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING