COPD Transition Referral Form

Communication of Care for COPD Transition Protocol

This patient participated in the COPD Transition Protocol ____________________

Admitting Diagnosis/Status: ____________________

Patient Hospitalization *(Date)*: ___ / ___ / ___

☐ COPD Education Session Provided

Comments: ____________________

Pulmonary Medications at Discharge:

____

____

____

Home O2 Assessment

O2 Saturation on Room Air: __________ Date: ___ / ___ / ___ Titration for O2: __________

Tobacco Cessation Information

☐ N/A

☐ Information Provided

☐ Patient Enrolled in Tobacco Cessation Program

☐ Patient Declined

Pneumonia Vaccine

Date: ___ / ___ / ___

Flu Vaccine

Date: ___ / ___ / ___

Sleep Disorders Assessment

☐ Epworth Sleepiness Scale Score: __________ (≥ 9 should consult sleep specialist)

☐ Apnea Link Performed Score: __________ ☐ Normal ☐ Abnormal

Therapist Signature: ____________________ Date: ___ / ___ / ___ Time: __________

Please Check the Appropriate Patient Referrals:

☐ Referral for Outpatient Pulmonary Function Test

☐ Referral for Outpatient Sleep Study

☐ Referral for Outpatient Pulmonary Rehabilitation

Physician Signature: ____________________ Date: ___ / ___ / ___ Time: __________

Please fax order to 802.747.6561 **Phone: 802.772.2626**

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