

## Lungs in Action Entry Form - GPs

Client name \_\_\_\_\_

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Contact number \_\_\_\_\_ Gender  Male  Female

Address \_\_\_\_\_

Email \_\_\_\_\_

**Emergency contact:** Name \_\_\_\_\_ Number \_\_\_\_\_

Relationship to client \_\_\_\_\_

**Client to sign:** I have received the Lungs in Action Information Form and give my permission for the Lungs in Action instructor to communicate with the referring clinician and/or my GP regarding my progress with Lungs in Action.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Has the participant completed a full course of Rehabilitation?**  Yes  No

Please tick all that apply to this client		
<p><b>Lung Conditions</b></p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchiectasis</p> <p><input type="checkbox"/> COPD</p> <p><input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis</p> <p><input type="checkbox"/> Cystic Fibrosis</p> <p><input type="checkbox"/> Pulmonary Fibrosis</p> <p><input type="checkbox"/> Interstitial Lung Disease</p> <p><input type="checkbox"/> Lung Transplant</p> <p><input type="checkbox"/> Sleep Apnoea</p> <p><input type="checkbox"/> Uses Supplemental Oxygen (uses oxygen during exercise? Y/N)</p> <p><input type="checkbox"/> Frequent exacerbations</p> <p><input type="checkbox"/> O<sub>2</sub> Sat continue to drop during recovery?</p> <p><input type="checkbox"/> Typical recovery times</p> <p><input type="checkbox"/> Action Plan Y/N</p>	<p><b>Heart Conditions</b></p> <p><input type="checkbox"/> Cardiac Procedures</p> <p><input type="checkbox"/> CABG <input type="checkbox"/> Stenting <input type="checkbox"/> Angioplasty</p> <p><input type="checkbox"/> Devices</p> <p><input type="checkbox"/> Pacemaker <input type="checkbox"/> AICD</p> <p><input type="checkbox"/> IHD/Angina</p> <p><input type="checkbox"/> Previous MI</p> <p><input type="checkbox"/> Heart Failure (EF: _____)</p> <p><input type="checkbox"/> AF</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Heart Valve Disease</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p> <p><input type="checkbox"/> Action Plan Y/N</p>	<p><b>Other Medical Conditions</b></p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Diabetes (Insulin dependant? Y/N)</p> <p><input type="checkbox"/> Frequent exacerbations</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Illiterate</p> <p><input type="checkbox"/> Kidney Condition</p> <p><input type="checkbox"/> Malnutrition</p> <p><input type="checkbox"/> Musculoskeletal (please specify)</p> <p><input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Panic Attack</p> <p><input type="checkbox"/> Parkinson's Disease</p> <p><input type="checkbox"/> Personal response plan</p> <p><input type="checkbox"/> Vision impaired</p>

If you checked any of the above, please provide more information about any necessary medication and/or how any of the above may relate to the patient's ability to exercise and any necessary modifications or movements that should be avoided. (Please attach additional information to this form.)

**Please attach a copy of the Final Week of Rehabilitation Exercise record sheet if available.**

I certify that this patient has medical clearance to participate in the low intensity Lungs in Action exercise maintenance program. This client must stop exercising if \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Doctor's Name \_\_\_\_\_ Business Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Fax \_\_\_\_\_

Lungs in Action was developed by The Australian Lung Foundation in conjunction with respiratory and heart failure physicians and pulmonary and heart failure rehabilitation experts. It is designed to be safe for those people who have completed pulmonary or heart failure rehabilitation programs and is run by specially trained instructors. It is suitable for people on supplemental oxygen. Not suitable for NYHA Class IV heart failure.