

*Insert program address and phone*

Date:

Dear

Your health professional has referred you to our pulmonary rehabilitation program.

This is a program for people with chronic lung disease and involves supervised exercise and education (a brochure is enclosed).

Before commencing this program an assessment is required so that we can prescribe an appropriate exercise routine for you.

**Assessment date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Wear:** Comfortable clothing and shoes.

**Bring:**

- A list of current medications
- Any walking aids if required
- Portable oxygen if required
- Your reading glasses if required
- If possible, it can be beneficial to bring your partner or support person

The appointment will take approximately 1:00 – 1:½ hours.

If you are not able to attend, or have any questions, please contact the co-ordinator (below) as soon as possible.

Yours sincerely,

*Insert name*

Pulmonary Rehabilitation Coordinator

*Insert contact details*