Pulmonary Rehab Post-COVID Recovery Referral

DATE______________________________ **REFERRING PROVIDER**____________________________

PATIENT NAME (PRINTED)____ **DATE OF BIRTH**___________________

PATIENT PHONE________________________________**ALTERNATIVE PHONE**_____________________________________

Patient is: ☐ **Tobacco Free** ☐ **on the following Smoking Cessation Regime**____________________________________

Screening and admission criteria: Must be post infection for 2-3 weeks and afebrile. Patient will undergo screening prior to each group session.

REFERRING DIAGNOSIS:

Primary (*symptom that necessitates recovery care***)**

CHECK ALL APPROPRIATE DIAGNOSIS BELOW (indicates GO424)*

____Chronic Bronchitis **J41-J42** *	____Emphysema **J43** *
____Chronic Obstructive Pulm. Disease **J44.9** *	Other Diagnosis____

______ Sequela of COVID-19 ***B94.8***

______History of COVID-19 ***Z86.19***

I authorize the Cardiopulmonary Rehabilitation Department to:

- Perform PFTs; Flow volume loop spirometry, to evaluate FVC/FEV_1; FEV_1
- Participate in the COVID Recovery Pathway
- Schedule a functional assessment; either a six minute walk and/ or symptom limited cardiopulmonary graded exercise test prior to starting pulmonary rehabilitation to help formulate an exercise prescription
- For patients already on oxygen therapy, allow licensed staff to titrate supplemental oxygen, in order to keep the SpO2 level ≥88% during the exercise session.
- Allow participation in group/individual counseling education sessions.
- Allow rehabilitation staff to develop an Individualized Treatment Plan (ITP) prior to the patient starting rehabilitation.
- Allow for Exercise prescription per protocol or ☐ Customize Exercise Treatment Plan ______________
  ____

I consent to have my patient participate in the pulmonary rehabilitation COVID Recovery program. I agree to allow my patient to participate in the outpatient phase III pulmonary rehabilitation COVID Recovery program after completion of the phase II program in if clinically indicated.

Date____________ **Provider Signature**____

PLEASE FAX COMPLETED FORM, H&P, DEMOGRAPHICS, AND COPY OF INSURANCE CARDS TO 855-264-1090