Pulmonary Rehabilitation Physician Referral Form

DATE________________ **REFERRING PROVIDER**____

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

PATIENT PHONE_______________________________**ALTERNATIVE PHONE**____________________________________

Patient is: ☐ Tobacco Free ☐ on the following Smoking Cessation Regime___________________________________

REFERRRING DIAGNOSIS:

CHECK ALL APPROPRIATE DIAGNOSIS BELOW (indicates GO424)*

____Chronic Bronchitis **J41-J42 ***

____Emphysema **J43** *

____Chronic Obstructive Pulm. Disease **J44.9** *

____Asbestosis **J61**

____Lung Replacement by Transplant **Z94.2**

____Pulmonary Fibrosis Unspecified **J84.1**

____Pulmonary Fibrosis Interstitial **J84.89**

____Other Lung Disease **J98.4**____

In order to qualify for Pulmonary Rehabilitation, patients must have a PFT with the last 3 months

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I authorize the Cardiopulmonary Rehabilitation Department to:

- Schedule PFTs to determine COPD GOLD Classification II, II, or IV (minimum required FEV1/FVC<70%; FEV1 <80%)
- 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 ______________
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I consent to have my patient participate in the pulmonary rehabilitation program. I agree to allow my patient to participate in the outpatient phase III pulmonary rehabilitation program after completion of the phase II program.

Date____________**Provider Signature**____

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