

**PULMONARY REHABILITATION
REFERRAL FORM**

Office 803-256-5687

Fax 803-256-5710

- 1) I would like to refer the following patient to the Pulmonary Rehabilitation Program at Providence Health. This program is designed to help the patient improve their daily activities through education, emotional support, and improved exercise tolerance.

Patient's Name: _____ DOB: ____/____/____

Address: _____ City _____ State _____

Home phone: _____ Work phone: _____ Zip code _____

Pulmonary Diagnosis: _____

Other Medical Problems: _____ Primary Physician: _____

Cardiac History: yes no Cardiologist (if applicable): _____

- 2) From a cardiac standpoint, the patient is cleared for exercise. Yes No

Comments: _____

- 3) Please check the protocol for oxygen therapy during exercise if needed:

If Oxygen saturation reads 88% or below at rest or during exercise, place patient on 2 liters per minute via nasal cannula and monitor exercise. Increase by 1 LPM after 2 minute intervals to a maximum 4 LPM until Oxygen saturations reach 88% or above.

Stop exercise and call primary physician if saturations remain less than 88% on 4 LPM.

Other Oxygen Therapy: _____

- 4) If patient is ineligible for Phase II pulmonary rehab, patient may participate in Phase IV/self monitoring.

5. All referrals must include a complete PFT with interpretation and an office note/H&P indicating a referral has been made to Pulmonary Rehab. All patients need to have been seen by referring MD within 3 months of referral.

Complete PFT unavailable, please schedule complete PFT at _____ to determine eligibility.

Ordering Physician: _____
(Please Print)

Physician Signature: _____ Date: ____/____/____ Time: _____