Providence
HEALTH

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: ________________

If there are any contraindications to this patient starting this exercise program, please indicate below: ______________

____

2) **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.

- ☐ Current Oxygen Therapy: ____
  Please maintain exercise SPO2 of ________________%

3) ☐ **All referrals must include a complete PFT with interpretation, a current walk exercise test 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.**

4) ☐ **Complete PFT unavailable, please schedule complete PFT at ____________________to determine eligibility.**

Ordering Physician: ____
(Please Print)

Physician Signature: ______________________________**Date:** _____/_____/_____ **Time:** _________

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