Pulmonary and Sleep Associates of Marin

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OUTPATIENT PULMONARY REHABILITATION
PHYSICIAN ORDER AND REFERRAL FORM

Patient Name:_____ **DOB:**_____ **M**__ **F**__
First **Last**

Diagnosis and ICD-10 code:_____

Thank you for referring your patient to our outpatient Pulmonary Rehabilitation program. Please sign this order and fax it along with the requested information to our office.

Order:

__Patient to participate in Pulmonary Rehabilitation Program twice a week for 6 weeks
__Oxygen therapy for oxygen saturation < 90% on room air
__Nebulized Albuterol 2.5 mg/2.5 ml as needed for shortness of breath or wheezing
__Graded exercise program
__Patient education on:

1. Anatomy/Physiology
2. Breathing Exercises
3. PEP and flutter valve
4. Home exercise program
5. Medications/Inhalers and proper usage
6. Respiratory Infection Identification
7. Proper diet
8. Panic control and stress reduction measures
9. Advanced Directives
10. Diagnostics
11. Respiratory Equipment
12. Smoking Cessation

In order to enroll your patient we must have: (__please order these tests for my patient)

1. History and Physical within 90 days.
2. PFT within 6 months
3. EKG and stress test within 1 year

The above patient has been seen by me within the past 3 months and is clinically stable to participate in outpatient Pulmonary Rehabilitation:

_____ _____ _____
Physician Name (please print) **Physician Signature** **date**

Referring physician contact phone: _____ fax: _____