Pulmonary and Sleep Associates of Marin

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OUTPATIENT PULMONARY REHABILITATION
PHYSICIAN ORDER AND REFERRAL FORM

PATIENT NAME: _____ **DOB:**_____ **M** ☐ **F** ☐

Diagnosis (ICD-10): ☐ COPD (J44.9); ☐ IPF (J84.112); ☐ ILD (J84.170); ☐ Long Covid (U09.9) ☐ PAH (I27.0)

Thank you for referring your patient to our outpatient Pulmonary Rehabilitation program. **Please sign and fax this order to 415-878-0215**.

Order:

- ☐ Patient to participate in your Pulmonary Rehabilitation Program for 10-12 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, supervised and monitored 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. Nutrition
8. Panic control and stress reduction measures
9. Advanced Directives
10. Diagnostics
11. Respiratory Equipment
12. Smoking Cessation

I am aware that one of your pulmonologists will evaluate my patient before the start of pulmonary rehabilitation and that certain diagnostic data (such as PFTs, 6-min walk test, CXR, EKG) may be required and will be requested by the program director if not already available.

Physical limitations to exercise or other precautions are: _____

_____ **Physician Name (please print)**

_____ **Physician Signature**

_____ **date**

Referring physician contact phone: _____ fax: _____