

*Pulmonary and Sleep
Associates of Marin*



100 Rowland Way, Suite 300
Novato, CA 94945

Phone: 415-878-0225
Fax: 415-878-0215

MarinPulmonarySleep.com

**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: _____