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◯
First Last

Diagnosis and ICD-10 code:_____ ☐ COPD (J44.9)

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: (or ☐ 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: _____