



**PULMONARY REHABILITATION
PHYSICIAN REFERRAL FORM**

Phone (919) 784-3756 Fax (919) 784-3442
4420 Lake Boone Trail Raleigh, NC 27607
1400 Timber Drive East Garner, NC,27529

Name: _____ DOB: _____
Address: _____ Phone: _____

PLEASE CHECK ALL THAT APPLY

PULMONARY REHABILITATION DIAGNOSIS:

- COPD
- Asthma
- Emphysema
- Chronic Bronchitis
- Fibrosis
- Sarcoidosis
- Lung Cancer
- Other _____

**Office and Discharge Notes are required for admission into Pulmonary Rehab. Please attach copy of PFTs, and Medical History with this referral form.*

Physician's Prescription for Pulmonary Rehabilitation

- [] Pulmonary Rehabilitation Sessions 3x a week for 20-30 sessions.
Stress Test if CAD Diagnosis.
Breathing Retraining
Bicycle/Treadmill/Airdyne/Arm Ergometer/Recumbent Stepper
Pulmonary Disease Education and Device Demonstration/Education
O₂ Administration if SpO₂<90%, titrate to maintain O₂ sat>90%
If unable to maintain SpO₂ sat >90% on pulse dose, may change to continuous flow and if needed may change oxygen system from gas to liquid or liquid to gas.
Aerosol RX with Albuterol PRN for SOB
Six minute walk test evaluated at entry and exit
Continuous straight flow O₂ order for weight bearing activities
Continue in Pulmonary Maintenance Program upon completion of rehabilitation if appropriate.
- [] Administer nitroglycerin 0.4mg sublingually at 5 minutes x 3 as needed for angina/ischemia.
- [] Simple Spirometry upon entry (if full PFT's have not been completed within last year)

I have examined the above patient and have found him/her medically qualified to participate in the above ordered activities.

Physician Name (First, Last, please print) Physician Signature Date/Time

Phone Number Fax Number

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