



**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:**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> COPD               | <input type="checkbox"/> Fibrosis    |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> 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  
O<sub>2</sub> Administration if SpO<sub>2</sub><90%, titrate to maintain O<sub>2</sub> sat>90%  
If unable to maintain SpO<sub>2</sub> 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 O<sub>2</sub> 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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**\*MDORD001\***