

Pulmonary Rehabilitation Program Exercise Referral Form

PARTICIPANT NAME: _____ DATE: _____

PARTICIPANT PHONE NUMBER: (H) _____ (W) _____

PHYSICIAN: _____ PHYSICIAN'S PHONE #: _____

REFERRAL TO: PULMONARY REHABILITATION – 30 sessions

 TO BE COMPLETED BY PHYSICIAN: **PLEASE FILL OUT ITEMS 1 - 8 COMPLETELY** Fax to: 443-643-3731

Please indicate all diagnoses that apply.
ICD-9 Code and Specific Date (00/00/0000) *Must* be included with diagnosis

<i>Diagnosis</i>	<i>ICD-9 Code</i>	<i>Date</i>
<input type="checkbox"/> Chr Airway Obstruct NEC	496	____/____/____
<input type="checkbox"/> Shortness of breath	786.05	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

 1. **Non-Pulmonary history:** _____

 2. **Exercise Prescription:** (Boxes **MUST** be checked)

 Per protocol Special recommendations: _____

 3. **Education:** (Boxes **MUST** be checked)

 Per protocol Special recommendations: _____

 4. **Counseling, Behavior Changes, Psychosocial Intervention:** (Boxes **MUST** be checked)

 Per protocol Special recommendations: _____

 5. **Participant has CARDIOVASCULAR CLEARANCE (per my recommendation):**
 YES NO Refer to PCP/Cardiologist: Dr. _____

 6. **Phone #:** _____ for cardiac clearance.

 7. **Participant is:** TOBACCO FREE

on the following smoking cessation program: _____

 8. **Participant is prescribed oxygen therapy.**
 NO YES: _____ L/min continuously at night other: _____

Physician Signature: _____

PLEASE SEND THE FOLLOWING MEDICAL INFORMATION:

- ✓ COMPLETED AND SIGNED Referral Form (this form)
- ✓ Current medications
- ✓ History/physical or discharge summary (reflecting most recent office visit)
- ✓ Recent 12 lead EKG (within last 6 months)
- ✓ Cardiopulmonary stress test results (if completed within last 3 months, if not, please send a separate prescription for one to be done here at UCH)
- ✓ Pulmonary Function Test results, with bronchodilator (if completed within last 3 months, if not, please send a separate prescription for one to be done here at UCH)
- ✓ Surgical report, if appropriate
- ✓ Any other relevant medical information, including cardiac history, if appropriate