Outpatient Pulmonary Rehabilitation Program
Physician Referral Form

Patient Name : _____ Date:_____
Diagnosis: _____ ICD 9 Code: _____
Other Medical Diagnosis: _____
DOB: _____ Patient Contact # : _____

Enroll patient in Outpatient Pulmonary Rehabilitation Program:

Pulmonary Rehabilitation Orders:

- Spirometry pre and post bronchodilator and diffusion capacity – *will be done if needed to qualify for pulmonary rehabilitation and if not done within three months prior to enrolling in program..*
- Perform comprehensive RT evaluation and monitor ongoing patient progress
- RT to perform baseline exercise tolerance test (six minute walk) pre & post program
- RT to perform MIP to assess for inspiratory muscle training
- Exercise and conditioning 2 -3 times a week for 6-10 weeks based on initial evaluation and ITP. (Dependent on site and ITP)
- Oxygen administration to maintain SpO2 > 90% with exercise
- Administer nebulizer treatment PRN times one with 0.083% unit dose albuterol sulfate inhalation solution (2.5 mg/3 ml) if SOB not alleviated with patient's rescue inhaler
- PT evaluation and treat if indicated by Pulmonary Rehab policy and procedure
- Dietary evaluation

This patient is capable of participating in a comprehensive pulmonary rehabilitation program, which includes the guidance and monitoring by a licensed respiratory therapist. Medical Director will oversee and establish the ITP (Individual Treatment Plan) and review care plan every 30 days.

_____ _____
Physician Signature **Physician (Print Name)**

Important

Please fax the following information with referral form to:

SMCA (512) 324-3326 SMCH (512) 504-5567
SMCW (512) 324-4688 Seton Smithville (512) 237-5725
Seton Highland Lakes (512) 715-3131

1. Latest H&P to include last office visit
2. Patient demographics
3. All pertinent diagnostic medical data (i.e. PFT's, EKG's, ABG's, lab work, etc.)
4. Patient medication list

For Questions call (512) 324-3325