Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

REFERRAL/PULMONARY REHAB

PF03028

PATIENT I.D.

Date of Referral: _____

Patient Name: _____ ICD-9 Code: _____

Date of Birth: _____ Other Medical Diagnosis _____

Address: _____ ICD-9 Code _____

City: _____ State: _____ Zip: _____

Telephone# _____

Pulmonary Diagnosis: _____

Pulmonary Rehab Referral Form

*** Please check boxes or complete:**

☐ **Standard PR Program (24-36 sessions, 3 per wk)**

Perform comprehensive RT evaluation and monitor ongoing progress
Oxygen initiation/titration to keep SaO2 ≥ 90% during exercise.
Individualized strengthening and conditioning exercise with each session.
Workload increase based on ability/Borg dyspnea 3-5
Individualized Treatment Plan including pulmonary health education and self-maintenance Training each session.
Pre and post program 6MWT and Outcome Assessments.
Dietary evaluation and treat by RD if indicated

☐ **Maintenance Exercise Program, Self-pay (up to 3 sessions per week after completion of standard program)**

Oxygen initiation/titration to keep SaO2 ≥ 90% during exercise.
Vital sign monitoring pre and post session (SpO2, HR, BP)

Treatment Request:

Pulmonary Rehab/Respiratory Therapy evaluate and treat
EKG (if one has not been done in past 6 months)
Complete PFT with & without bronchodilators & DLCO (if not done in past year)
Qualifications are as follows:

COPD - ***FEV1/FVC < 70% actual, AND FEV1 < 80% predicted.***
NON-COPD - FVC, FEV1 or DLCO < 65% of predicted.

I certify that I have seen and examined this patient within the last 90 days, that these services are necessary, and that this patient remains under my care. The patient is willing and able to participate in pulmonary rehab, and is not smoking or is currently in a smoking cessation program.

☐ **This patient is cleared from a cardiac standpoint to participate in the exercise and conditioning based on the evaluation and Individual Treatment Plan.**

☐ **This patient is not cleared from a cardiac standpoint and will be referred to Cardiology for clearance to participate.**

Physician's Signature: _____ **Date:** _____ **Time:** _____

Medical records required:
_____H&P (within 90 days)
_____PFT's (within the last year)
_____EKG (can be done by PR staff)

Medical records (if available)
_____CXR
_____ABG's