Wilkes Medical Center
1370 West D Street.
North Wilkesboro, NC 28659
Phone: (336)-903-6980 Fax: (336) 903-6981 or (336) 651-8761

Pulmonary Rehabilitation Physician Referral and Exercise Prescription

Patient's Name:	DOB:	**MR#:**
Address: **City:**		**State:** **Zip:**
Telephone: Home ( )	**Daytime ( )**	

Diagnosis: □ COPD (J.44.9) □ Chronic Bronchitis (J42) □ Emphysema (J43.9)
□ Bronchiectasis (J47.9) □ Interstitial Lung Disease (J84.9) □ Pulmonary Fibrosis (J84.10)
□ Pulmonary Hypertension (I27.20) □ Asthma (J45.40)

Other: _____

Date of Diagnosis *(if known)*:

Reason for Referral: (*May attach copy of ABGs, PFTs H&P, Medications, Progress Notes):*

Disease Related Complications/ Exercise Limitations:

Physician Order

	Assessment and establishment of Individualized Treatment Plan (ITP) by Pulmonary Rehabilitation (PR) Staff, PR Medical Director and/or Referring Physician prior to initiating PR services
	ITP to be reviewed by PR Medical Director every 30 days
	Maximum of 36 sessions, 2 times per week for 31 to 60 minutes duration, based on patient progress as determined by ITP
	Each session to include a component of aerobic exercise
	Pre/Post Resting and Exercise oximetry (six minute walk test) and PRN to evaluate progress
	May titrate/initiate Oxygen Therapy to achieve SpO2 ≥90% OR _____
	Nebulized Treatment of 2.5 mg Albuterol PRN for severe wheezing, dyspnea. Notify MD if given.
	Implement all exercise and education modalities and progress according to ITP
	Home exercise program according to ITP
	Hold exercise and notify MD if Blood Sugar >300
	Hold exercise and notify MD if Resting SBP >200 or DBP >110
	PROGRAM MODIFICATION (S) – please indicate any modification(s) to the above orders:

Other:

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

_____
Physician Name (Please Print) Note: Must be MD/DO

_____ _____
Physician Signature ***Date/Time Signed***