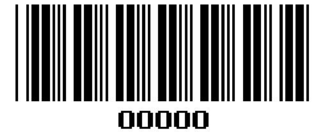
ST. JOSEPH'S Hospital Health Center

7246 Janus Park Drive
Liverpool, NY 13088

Please Place Patient Label Here
DO NOT COVER BARCODE



PULMONARY REHABILITATION PROGRAM
REFERRAL FORM

Patientøs Name: ______________________________ DOB: ____________________

Patientøs Phone: ______________________________

DIAGNOSIS:

- ❑ COPD
- ❑ Pulmonary Fibrosis
- ❑ Post thoracic surgery: __________
- ❑ ASTHMA
- ❑ Interstitial Lung Disease
- ❑ Other: __________________

MEDICAL CONTRA-INDICATIONS:

- Unstable ischemic heart disease
- Uncontrolled pain
- Morbid obesity: > 350 lbs.
  (Exceeds weight limit for equipment)
- Severe pulmonary hypertension
- Disabling stroke
- Disabling orthopedic conditions
  (Which limit LE ROM)

REFERRED FOR:

Pulmonary Rehabilitation Program:

- ❑ Exercise Training AND Education

NOTE: Six Minute Walk is performed as part of initial assessment

Better Breathing Program:

- ❑ Education ONLY: Disease Management

PLEASE SEND:

- ✓ Most recent PFTøs
- ✓ Most recent office note
- ✓ Patient demographics
- ✓ Insurance information

It is my determination that this patient is able and motivated to participate in a pulmonary rehabilitation program.

______________________________ ______________________________
Physicianøs Signature Date

______________________________ ______________________________
Physicianøs Name (please print or stamp) Phone

Please FAX to (315) 458-5715 St. Josephøs Cardiopulmonary Rehabilitation Program
For more information, please call (315) 458-7171