TOBACCO FREE CAMPUS

NGMC Gainesville	NGMC Braselton
770-219-8264	770-848-7192
Fax: 770-219-8262	Fax: 770-219-3317

Patient Name: ____ **DOB:** ____________________

Phone: Home: ________________________________ Cell/Work: ______________________________

Diagnosis:

- ❑ COPD
- ❑ Emphysema
- ❑ Chronic Bronchitis
- ❑ Interstitial Lung Disease
- ❑ Idiopathic Pulmonary Fibrosis
- ❑ Other: ____________________________

This individualized pulmonary rehab Phase II and Phase III program is medically necessary for the continued improvement of this patient.

REQUIRED DOCUMENTS:

- ❑ Patient Demographics / Copy of Insurance Cards
- ❑ Current H&P Note
- ❑ Current PFT ≤ 12 months

> Medicare requires that a **COPD** patient meet Gold Stages II -IV
> **FEVI < 80% Predicated**
> **FEVI/FVC < 70% Actual**

PROGRAM INCLUDES: Pre/Post 6MWT, educational classes, individual nutritional consultation, medication review. Patients exhibiting consistent improvement in functional capacity may be increased in 0.5-1 MET increments. **Limited to respiratory therapist guided:** Aerosol therapy (2.5mg Albuterol c 3cc NSS via nebulizer) PRN for SOB. Oxygen therapy for exercise Sp02 below 88% per oximeter.

Increases in workloads will be initiated when the following criteria are met: Exercising blood pressure less than 210/100. Exercising heart rate does not consistently exceed +30 of resting heart rate. Patient maintains an oxygen saturation ≥ 86%. Dyspnea ≤ 4 on a 0-10 dyspnea scale.

To the best of my knowledge this patient is motivated to participate in the pulmonary rehab program.

____ ____________________

Physician Signature **Date**

Physician Dictate ID # or printed name: ______________________________________

PATIENT IDENTIFICATION:

PULMONARY REHAB
PHYSICIAN REFERRAL