Pulmonary/Respiratory Rehabilitation Program
Physician Referral

Patient Name: _____ Date of Birth: _____Phone: _____

Insurance: _____

Includes Assessment, Intervention, Education, Goal Setting for the progression of: Exercise Training, Respiratory Therapy, Nutrition, Psychosocial, Medications and Oxygen Use

Referred to Location:

- ☐ **Auburn Medical Center**
  - Please fax this form to: *(253) 403-4386*
- ☐ **Tacoma General Hospital**
  - Please fax this form to: *(253) 403-4386*
- ☐ **Capital Medical Center**
  - Please fax this form to: (360) 956-1930
- ☐ **Deaconess Hospital**
  - Please fax this form to: *(509) 603-2039*
- ☐ **Valley Hospital**
  - Please fax this form to: *(509) 473-2039*

Diagnosis, PFT and Oxygen Order

The following are usually covered by most insurance. A **recent PFT** is required to enroll in the program. *Please check appropriate diagnosis:*

- ☐ COPD (Includes Emphysema & Chronic Bronchitis) – MUST be: (please check severity)
  - ☐ Moderate
  - ☐ Severe
  - ☐ Very Severe
- ☐ Post-COVID-19 Condition
- ☐ Interstitial Lung Disease
- ☐ Idiopathic Pulmonary Fibrosis
- ☐ Pulmonary Fibrosis: Specify Type: _____
- ☐ Asthma – MUST be chronic, persistent: (please check severity)
  - ☐ Moderate
  - ☐ Severe
  - ☐ Very Severe
- ☐ Pulmonary Artery Hypertension
- ☐ Lung Volume Reduction Surgery (LVRS); Date: _____
- ☐ Lung Transplant; Date: _____
- ☐ Other Diagnosis: _____
- ☐ ***Oxygen Order & Oxygen Saturation Monitoring during exercise training***

  Rest: _____Lpm via cannula, Exertion: _____ Lpm via cannula

  Supplemental Oxygen up to _____Lpm via cannula to maintain SpO2 greater than _____%

Physician's Name: _____ **Fax Number:** _____

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