Monadnock
COMMUNITY HOSPITAL

# Pulmonary Fitness Program
# Referral Form

Patient _____ DOB _____/_____/_____

Address _____ Phone _____

Physician _____ MD Phone _____

MD Fax _____

Insurance (1) _____ Insurance (2) _____

Diagnosis: _____

_____

ICD-10 Code(s): _____

**Eligible diagnoses include:** *COPD, Emphysema, Chronic Bronchitis, Pulmonary Hypertension, Pulmonary Fibrosis, Interstitial Lung Disease, Lung Cancer, Pre & Post Lung Transplant, OSA, Frequent Pneumonia, Asthma, AAT*

*Description*

- Pulmonary Fitness is a ten-week program that meets twice per week. It is designed to reduce symptoms, optimize functional status, and reduce health-care cost through stabilization of the disease. The program includes patient assessment, exercise training, education and psychosocial support.
- A 6 Minute Walk Test is part of the initial evaluation and is repeated at the conclusion of the program to assess pre/post functional status and oxygen needs.
- Titrate/initiate oxygen to maintain SaO2 ≥88%.

**A Pulmonary Function Test is helpful in diagnosing, staging and guiding treatment of chronic pulmonary disease.**

**Please send the following if available**

- *EKG: If not done within the past year, obtain new EKG prior to referral*
- Most recent PFT or Spirometry
- Most recent office note
- Recent labs
- Recent pertinent X-rays/scans
- Most recent specialist note (pulmonologist, cardiologist)

Name of Physician/PA/NP (Please Print) _____ Date _____

*Signature of Physician/PA/NP* _____

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