Pulmonary Fitness Program

Bond Wellness Center
at MONADNOCK COMMUNITY HOSPITAL

Physician Referral

Patient Name:_____ **D.O.B.**_____

Address _____ **Phone** _____

Physician _____ **MD Phone**_____

Insurance: (1)_____ **(2)**_____

Diagnosis _____ **MD Fax** _____

Dear Dr. _____,

Your signature and completion of this form verifies that your patient meets all of the proposed criteria for Pulmonary Fitness. If any of the required testing has not been done in the recommended time frame you will be contacted, asked to order test(s) and forward results to the Pulmonary Fitness Program.

- This patient has quit smoking or will be participating in a smoking cessation program &/or 1:1 counseling.
- The patient has had a Pulmonary Function Test or Spirometry within the last twelve months.
- I have examined this patient in the last ninety days and have determined that this patient is capable of participating in the Pulmonary Fitness plan of care.
- The patient has a diagnosis of a chronic, yet not acutely decompensated respiratory impairment that is under optimal medical management.
  - ❑ *The patient exhibits symptoms of breathing impairment and or fatigue that produces a significant disability. This disability may include limitations in social activities, family and leisure activities, employment, and home chores, ADL's or the loss of personal independence.*

The following tests and information are **required** before admission to the program. If they are not available you will be contacted and asked to order them:

Required

1.	**EKG within last 12 months**	☐ **attached**	☐ **I will order & forward results**
2.	**PFT (or Spirometry) within the last 12 months**	☐ **attached**	☐ **I will order & forward results**
3.	**Most recent oxygen saturation or ABG**	☐ **attached**	☐ **I will order & forward results**
4.	**CXR within the last 12 months**	☐ **attached**	☐ **I will order & forward results**
5.	**CBC within the last 12 months, theophylline level if appropriate**	☐ **attached**	☐ **I will order & forward results**

6**. Cardiac Testing, *one must be selected:***

- ❑ Exercise stress testing, ***required*** if patient has had a cardiac event in the last ***six months***
- ❑ The patient has not had a stress test and based on my clinical judgment does not need one
- ❑ ETT will be completed prior to starting program on: _____

Physician Signature: _____ Date:_____

PA / NP Signature: _____ Date: _____

Please return with all patient reports and most recent H & P / Office Note to:

Essy Moverman RRT,RCP,AE-C,TTS Pulmonary Fitness Program

Phone # 603-924-4699 x4291 Fax # 603-924-4634/924-4651