GRIFFIN HEALTH

GRIFFIN HOSPITAL PULMONARY REHABILITATION PHASE 2 REFERRAL AND PLAN OF CARE

Patient Name: _____DOB: _____Today's Date: _____

Diagnosis/Procedure with Date:

COPD/**Date:** _____ Lung Cancer/**Date:** _____

Sarcoidosis/**Date:** _____ Interstitial Lung Disease/**Date:** _____

Lung Volume Reduction Surgery/**Date:** _____ Lung Transplant/**Date:** _____

Post COVID-19 Symptoms (ICD-10 U09.9 & persistent symptom)/**Date:** _____

Persistent Symptom due to COVID-19:_____

Other Obstructive/Restrictive disorder not listed/**Date**:_____

Exercise Prescription: (Check One):

Intensity:

____ Follow Exercise Prescription of RT or Exercise Physiologist (Recommended)

OR

____ 40-85% of Age Predicted HR

_____BPM above RHR

____ Borg RPE of "10-13"

____ Oxygen Saturation > or = to 88%

Frequency: 2 times per week

Mode: Continuous or intermittent aerobic exercise as tolerated

Strength Training: Increase resistance exercises as tolerated

Surveillance: Continuous pulse-oximetry monitoring during exercise; daily weights, Dyspnea, lung assessments for patients with COPD.

Emergency Orders will be implemented if needed:

Notification of Referring MD for any deterioration in patient's clinical status.

For Cardiac Related Chest Discomfort or Acute Bronchospasm: Evaluate and transfer to the Emergency Department through Rapid Response/911 Call as outlined in department Emergency Plan.

Physician Signature: _____ Date/Time: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

PLEASE FAX THIS COMPLETED FORM WITH; ☐ ***CURRENT OFFICE NOTE,*** ☐ ***DC SUMMARY,*** ☐ ***12-LEAD ECG,*** ☐ ***PERTINENT LABS,*** ☐ ***PFT (including DLCO,FVC,&FEV1),*** ☐ ***ARTERIAL BLOOD GAS ON ROOM AIR, AND*** ☐ ***CHEST XRAY TO 203-732-1418. Call 203-732-7106 with questions.***