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**:_____

Oxygen Prescription: (Complete if applicable)

Prescribed Oxygen: ____LPM **or** ____Room Air
Provider specifies ____ LPM of Supplemental Oxygen if Oxygen Saturation is ≤_____%
Provider Preferred Oxygen Saturation Range with Exercise____-____%
(Supplemental O2 to be used if Oxygen Saturation is <88% via RT discretion unless otherwise specified above)

Exercise Prescription:

Intensity:
____ Follow Exercise Prescription of RT or Exercise Physiologist

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), TO 203-732-1418. Call 203-732-7106 with questions.***