North Wind'rs Pulmonary Rehabilitation Program
Medical Referral & Exercise Plan

Patient's Name_____ **Telephone** _____**DOB**_____
Address_____ **City**_____ **Zip**_____
Referring Physician _____**Telephone** _____
Address _____ **City** _____**Zip**_____
Pulmonary Diagnosis: (please choose one)
FEV1/FVC <70%; FEV1 50-80% ____Moderate COPD
FEV1/FVC <70%; FEV1 30-50% ____Severe COPD
FEV1/FVC <70%; FEV1 <30% ____Very Severe COPD

Has this patient been tested for Alpha-1 Antitrypsin Deficiency? Yes No
Date of last CXR: _____
Cardiac History: ____CHF ____Prior MI Date: _____
____Angina ____Arrythmias Type:_____
____Cor Pulmonale ____Prior EKG? Date:_____

Current Medications:
_____
_____
_____

Known Allergies:
_____
_____

Other Medical Problems:
_____
_____

Exercise Parameters:
Physical conditions that may limit exercise: _____
_____
Oxygen use: Yes No **Type**: Continuous Flow Pulse Dose **Liter Flow**: _____
SpO2 parameters for exercise: (circle one) ≥87% ≥90% ≥92% Other: _____
Please note: We will adjust supplemental oxygen to keep patient's SpO2 within these parameters, including use of devices such as nasal cannula, oxymiser, and oxygen mask as needed.

Any other comments/suggestions regarding your patient's exercise plan:
_____
_____

Delivery & Instruction of respiratory equipment where applicable:
MDI with aerochamber; Acapella mucus clearing device; Pflex Inspiratory muscle trainer.

Please send a **History & Physical, CXR**, as well as **Pulmonary Function Tests** done within the last 6 months. It is important that we have this baseline information on each patient. If you do not have any recent PFT's, the patient will be set up to have Pulmonary Function studies completed prior to the start of the program. Any questions or concerns, please call us at 763-581-4297.

A mid session report on your patient's progress in pulmonary rehabilitation will be sent to you for your review. A formal ending progress report will be sent to you upon your patient's completion of pulmonary rehabilitation.

M.D. Signature_____ **Date**_____

Please fax or mail the information requested using the contact information below:
North Wind'rs Respiratory Care, North Memorial Health,
3300 Oakdale Ave. N, Robbinsdale, MN 55422.
Fax**:** 763-581-4291