CMC Pulmonary Fitness
CATHOLIC MEDICAL CENTER

Patient Identification Label
Patient Name:
DOB:

PHYSICIAN REFERRAL

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

Referring/Primary Provider: _____

Diagnosis: _____

Dear _____

Your signature and completion of this form verifies that your patient meets all of the proposed criteria for Pulmonary Fitness.

- 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.
- This patient has a diagnosis of a chronic but not acutely decompensated respiratory impairment and is currently under optimal medical management.
- This patient exhibits symptoms of breathing impairment and/or fatigue that produce a significant disability. The disability may include limitations in social activities, family and leisure activities, employment, ADLs, or the loss of personal independence.

The following tests and information are required before admission to the Pulmonary Fitness program:

• 12-lead ECG within the last six months	Please attach ECG.	A 12-lead ECG will be ordered on behalf of the referring provider if one has not been performed in the past 12 months. Results will be sent to the provider and will need to be forwarded to the Pulmonary Fitness office.
• Full PFT or screening spirometry within the past 2 years	Please attach PFT interpretation.	Screening spirometry will be ordered and performed by the Pulmonary Fitness staff on behalf of the referring provider if testing has not been performed in the past 2 years. Results will be sent to the provider.
• H&P/office visit note	Please attach H&P/office note	
• Exercise stress testing is recommended if the patient has experienced a cardiac event in the past six months	Please attach stress test if applicable	CMC1613

My signature certifies that the patient has been evaluated and in my opinion does not need further cardiac stress testing prior to participating in the Pulmonary Fitness Program.

Upon completion of the Pulmonary Fitness Program, my signature certifies that I find no contraindications to this individual participating in the Community Phase Exercise Program of the Department of Cardiovascular Wellness, including a progressive light weight resistance program of 1-10 lb handheld weights and elastic bands.

Physician Signature	Physician Name (print)	Date	Time