BreatheSuite

(T) 602-362-4466
(F) 623-294-6185

Virtual Pulmonary Rehabilitation Program Provider Referral Form

Please include the following:

- This signed referral form
- The patient's most recent office note with updated medications listed
- The patient's insurance information (front and back copy of cards if available)

Patient's Name: _____ **DOB:** _____

Phone Number: _____

Is the patient prescribed supplemental oxygen? ☐ yes ☐ no

Does the provider give permission for physical therapists/respiratory therapists to instruct the patient to titrate oxygen appropriately during exercise to maintain SpO2 >88-90%? ☐ yes ☐ no

Reason for Referral:

☐ COPD: ☐ Chronic Bronchitis ☐ Emphysema ☐ Alpha-1 Antitrypsin Deficiency

☐ Interstitial Lung Disease ☐ Bronchiectasis

☐ Post-COVID ☐ Asthma

Most recent pulmonary function test results (if available):

FEV_1: _____ FEV1% predicted: _____

FVC: _____ FVC% predicted: _____

FEV_1/FVC % predicted: _____

6-Minute Walk Test Results (if available):

Distance: _____

Supplemental O_2: _____

Assistive Device Used: _____

Provider's Orders: Physical Therapy Initial Evaluation and Treatment ☐ I agree

SIGNATURE REQUIRED FOR REFERRAL

Provider's Name: _____ **Date:** _____

Provider's Clinic: _____

Provider's Signature: _____

Medical Assistant Name & Contact: _____