Pulmonary Rehabilitation Physician Order

Patient Information:
Patient Name:_____ D.O.B._____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

Admitting Criteria (please circle all that apply):

Obstructive Diseases:
COPD – Chronic bronchitis, Emphysema,
Asthma, Bronchiectasis, Cystic Fibrosis

Restrictive Diseases:
Interstitial fibrosis, Sarcoidosis, Kyphoscoliosis,
Spondylitis, Parkinson's disease, Multiple sclerosis

Other:
Lung Cancer, Pulmonary hypertension, Volume
reduction surgery, Morbid obesity, Sleep apnea

Onset Date: _____

Exercise Prescription:
Therapy administered by Exercise Physiologists.

Mode(s) of Exercise:
___Treadmill
___Stationary Bike
___Upper-body Ergometry
___Stair Climber
___Elliptical Trainer
___Rower
___Nustep
___Resistance Training

Intensity: Target Heart Rate:_____
RPE:_____
Frequency: _____days per week
Duration: _____minutes
Length of Program: _____weeks
Supplemental Oxygen: _____L

Physician Signature:_____ **Date:**_____

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