McLaren Greater Lansing
PULMONARY REHABILITATION REFERRAL FORM

Mailing Address: Respiratory Services
McLaren Greater Lansing
401 W. Greenlawn
Lansing, MI 48910

SCHEDULING
Phone Number: (517) 975-6653
Fax Number: (517) 975-6660

CLINIC
Phone Number: (517) 975-6400
Fax Number: (517) 975-7062

Minimal Criteria for program coverage: PFT testing should be done within the year of the referral to Pulm rehab.

COPD qualifications: FEV1/FVC <70% and/or FEV1<80%
NON-COPD: FVC, FEV1, or DLCO<65%

REFERRAL DATE _____ INSURANCE _____

PATEINT NAME _____ PHONE _____

ADDRESS _____ CITY _____ ZIP _____

BIRTH DATE _____ AGE _____ DIAGNOSIS _____

ORDERING PHYSICIAN _____

PRIMARY PHYSICIAN: _____

PATIENT USING SUPPLEMENTAL 0_2? YES ☐ NO ☐ USAGE _____

PLAN OF TREATMENT:

- ☐ Training and Education of Disease Process
- ☐ Exercise
  - ☐ Per routine protocol (60-80% maximum HR)
  - ☐ Low level protocol (HR increase of 20-30 beats)
  - ☐ Other _____ Target HR _____
- ☐ Nutrition Counseling
- ☐ Activies of Daily Living review
- ☐ Stress Management
- ☐ Enroll in IRMC smoking cessation class

Please forward the following information to ensure that the patient is entered in the program as soon as possible.

1. Summary by phsician of medical history/medicines/physical exam and/or copy on admission/discharge if within 12 months.
2. EKG, chest x-ray and ABG reports within last 12 months
3. Complete Pulmonary Function test (Call 975-6653 to schedule if necessary)

Signature: _____ **Date:** _____

Physician Address: _____ **Phone :** _____