Wuesthoff Cardiopulmonary Rehabilitation
Physician Referral
Phone (321) 636-2052
Fax (321) 636-6481

Referring Physician _____ Date _____

Patient Name _____ Phone # _____

Diagnosis:

_____ Asthma

_____ Chronic Bronchitis

_____ Emphysema

_____ Other _____

Date of Illness _____ Hospital _____

Medical History _____

Restrictions

Procedures to include:
Six-minute walk test
Regular O2 Sat monitoring
Blood Pressure Monitoring
Telemetry Monitoring PRN

Pulmonary Function Test is required
_____ Recent results included
_____ Scheduled with patient

Based upon known medical/surgical history of the above patient, I am of the opinion he/she is capable of participating in the Pulmonary Rehabilitation Program.

Signature _____ Date _____