CLAY COUNTY HOSPITAL
Your #1 Choice in Healthcare

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Pulmonary Rehabilitation Order Form

Facility Name:	**Ordering Physician:**		
Patient Name:	**DOB:**	**DATE:**	**TIME:**

The above named patient is capable and willing to participate in our Pulmonary Rehabilitation program 2 days per week for a total of 10 weeks, to include:

Please mark all that apply			
Acapella		NuStep	
Aero Chamber for inhaler		Oxygen w/ exercise to maintain SpO2 ≥ 90%	
Air Dyne Bike		Peak Flow Meter	
Arm Ergometer		Pulmonary Education	
Assessment/6 Minute Walk Test		Recumbent Bike	
CPT/PD or Chest Vest		Resistance Training	
HHN w/ 2.5 mg Albuterol/NaCl PRN		Static/PNF Stretching	
Incentive Spirometry		Treadmill	
Inspiratory/Expiratory Muscle Trainer			
Complete PFT with FVC,FEV1, or DLCO< 65% of predicted normal, within one year prior to initiating Pulmonary Rehab services			

Diagnosis: _____

Comments: _____

_____

Physician Signature: _____

Physician Printed Name: _____