Pulmonary Rehab

Pulmonary Rehabilitation is designed for persons with chronic lung disease such as emphysema, chronic bronchitis, asthma, bronchiectasis and interstitial lung disease. Pulmonary Rehab provides a level of exercise training and education beyond that which is ordinarily covered by a physician during an office visit.

Admission Criteria:

- Participants entering the program must have physician referral
- Participants must be clinically stable as determined by the referring physician
- Participants must have a physician diagnosis of chronic obstructive, interstitial, occupational or environmental lung disease
- Participants must be non-smokers or participating in a smoking-cessation program

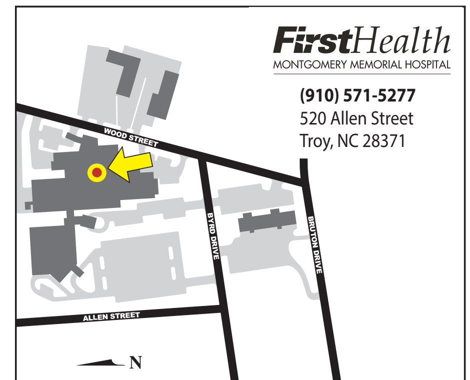
Pulmonary Rehabilitation Helps People with Lung Disease

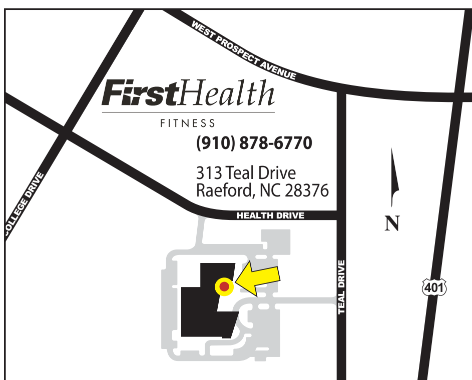
Pulmonary Rehab offers individuals with lung disease the opportunity to improve their quality of life by restoring them to their fullest functional capacity. This program includes:

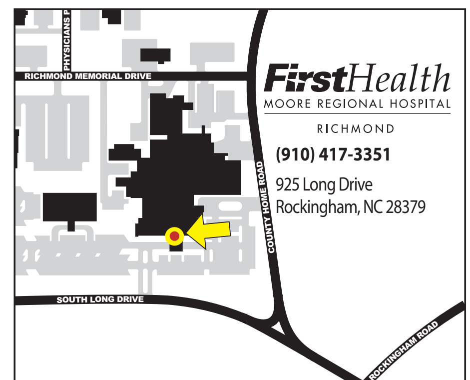
- Medical management
- Exercise
- Education
- Breathing retraining
- Emotional support
- Relaxation techniques

Benefits To You & Those You Love

- Reduced number of hospitalizations
- Improved exercise tolerance and level of physical activity
- Improved quality of life
- Potential for return to gainful employment in some participants
- Improved feelings of hope, control and self-esteem
- Improved psychological function with less anxiety and depression
- Family education, involvement and support
- Reduced shortness of breath & respiratory symptoms







EPIC: REF3045000

26-41-0003

7005.03.15338.06 Sunset Date: 5/2029

Place Patient Label Inside This Box

☐ Moore Regional Hospital - Richmond
(910) 417-3351
Fax (910) 417-4359

☐ Moore Regional Hospital
(910) 692-9103
Fax (910) 692-2103

☐ Hoke
(919) 878-6770
Fax (910) 692-2103

☐ Montgomery Memorial Hospital
(910) 571-5277
Fax (910) 572-5478

Pulmonary Rehabilitation/Respiratory Services Medical Assessment and Order Form to be completed in the physician's office and be faxed to the appropriate Pulmonary Program (above)

Name:_______________________________ Sex:_________ Age:_____ DOB:___________

Mailing Address:_____________________________ City:__________________ State:_______ Zip:_________

Phone #:_____________ Physician:______________________ Physician Phone #:________________

Physician Fax #:__________________

Dear Physician:

If you feel that your patient is a candidate and would benefit from Pulmonary Rehab/Respiratory Services based on the criteria below, please provide:

- Pre and Post Pulmonary Function Test
- Chest X-Ray
- Labs
- EKG

The criteria below must be met:

- Exhibits disabling symptoms, which significantly impairs the patients level of functioning
- Be physically able, willing and cooperative to participate
- Capable of participating in plan of care
- 6 minute walk test: pre- and post-program
- Non-smoker or willing to participate in a smoking cessation program.

I certify that the above Pulmonary Rehabilitation/Respiratory Services treatment is medically necessary and is medically approved by me for the treatment of this patient and this patient had a physical exam in the **last 90 days.**

Diagnosis:____ ICD-9 Code:______________

GOLD Classification: ☐ 0:At Risk ☐ I:Mild ☐ II:Moderate (IA) ☐ III:Severe (IB) ☐ IV: Very Severe

Refer to FirstHealth Smoking Cessation: ☐ Yes ☐ No

Physician Signature____

Date:______________________ Time:_____________________