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ASTHMA & LUNG CENTER

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Physician Order Form

Patient: _____ (Please fill in or attach patient demographics) DOB: _____ Phone: _____ Insurance: _____ Subscriber ID: _____	ICD-10: _____ Diagnosis: _____ Current Findings: _____ _____ _____

Significant Medical History:
Special Instructions / Precautions / Contraindications:

Frequency and Duration

Therapeutic Exercises for Respiratory Diagnoses:	_____times/week for ____weeks
Physical Therapy for Strengthening and Endurance:	_____times/week for ____weeks

Services:
- Assessment by Physical Therapy, Respiratory Therapist, MSW
- Therapeutic exercise, nutrition, and breathing retraining
- Assistance with and/or instructions in Activities of Daily Living (ADLs)
- Education and training; Balance training
- Bronchial hygiene and aerosol medications, if indicated
- Pulmonary function tests (PFTs), if needed

Goals:
- Increase activity tolerance and endurance in ADLs
- Increase ability to cope with disease and limitations
- Increase knowledge of disease and therapies
- Develop effective breathing techniques

The following baseline evaluation procedures MAY be performed for patient progress evaluation, if indicated:

☐ Body Composition Analysis
☐ Balance Testing
☐ Spirometry Testing
☐ Oxygen Titration
☐ The Six Minute Walking Test

Other Orders

1. Patient may be given oxygen as needed: Yes ☐ No ☐
2. Patient may be given HHN treatment as needed with: Yes Albuterol Yes Atrovent
3. In case of cardiopulmonary arrest: ☐ Do proved CPR and Call 911 ☐ DO NOT Provide resuscitation

Physician Name:	NPI:
Physician's Address:	Phone:
Physician's Signature:	Fax:

Please fax this form along with patient demographic information.