



A Comprehensive Outpatient Rehabilitation Facility

Patient Name _____

Patient Phone# _____ Patient Date of Birth _____

Date patient was last seen in your office _____

Reason for referral: (please circle)

COPD	Emphysema	Asthma	Chronic Bronchitis	Restrictive Lung Disease
OSA	Lung CA	CHF	Paralyzed Diaphragm	Pulmonary Hypertension
Obesity	S/P Lung surgery	CAD	Other _____	

Precautions: (please circle)

↓ SpO₂ Hypertension Diabetes Cardiac Disease Anticoagulant Tx

Rx:

OUTPATIENT PULMONARY REHABILITATION SERVICES

Dr. _____ NYS License# _____

Address _____

PH#: _____ FAX#: _____

Physicians Signature _____ Date _____

**FAX COMPLETED FORM WITH PATIENT DEMOGRAPHICS
AND THE MOST RECENT PFT'S TO (516) 302-8502 or (631) 951-0044**