PCH RESPIRATORY PROGRAM REFERRAL FORM

Date: ______________ PCH: ________________________ Attending Physician: ______________________

PCH Referring Person: ____ Phone # ____________________

1. Respiratory Diagnosis (indicate all that apply)
   - ☐ COPD
   - ☐ CHF
   - ☐ Pneumonia
   - ☐ Pulmonary Fibrosis
   - ☐ Asthma
   - ☐ Lung Cancer
   - ☐ Other ____

2. Respiratory therapy currently being received:
   - ☐ Oxygen Flow rate: ______lpm Current SpO2:_______
   - ☐ Inhalers ☐ Aerosol Therapy
   - ☐ Other respiratory therapy ____

   List Respiratory/Cardiac Medications + frequency (or attach a copy of the MAR) ____________________

   ____

   ____

3. Services requested:
   - ☐ Respiratory assessment. Provide reasons for request: ________________________________

     ____

     ____

     ____

   - ☐ Arterial blood gas done on: ☐ room air ☐ 0_2 @ _____lpm
   - ☐ Spirometry (client ***must*** be able to follow instructions, very effort dependent test)
     Current height:_________ Current weight:_________
   - ☐ Oximetry ☐ Walking oximetry ☐ Overnight oximetry
   - ☐ Other ____

   Note: Physician's order needed for ABG, Spirometry, and Overnight oximetry

Fax referral form to: 832-0619
If any further questions call 837-1301 ext 2206