ASTHMA & LUNG CENTER

asthmalungcenter.com

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Physician Order Form

Patient Name:	DOB:	Date:
Diagnosis / ICD-10:	Patient Phone:	
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.
2.	Patient may be given HHN treatment as needed with: Albuterol Atrovent
3.	In case of cardiopulmonary arrest: DO provide CPR and call 911 DO NOT provide resuscitation

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

Please fax this form along with patient demographic information.