I would like the following person to be screened for participation in exercise sessions and educational programs offered by the Wentworth−Douglass Hospital Pulmonary Rehabilitation Program.

Name: _____ DOB: _____

Diagnosis: _____

Date of most recent hospital admission for COPD: _____

Please forward the following information with your referral to:

Wentworth−Douglass Hospital
Pulmonary Rehabilitation Program
789 Central Avenue
Dover, NH 03820
Fax (603) 609−6023

1. Medical history and physical exam report (within 90 days)
2. Pulmonary Function Test (within one year)*
3. 6−minute walk test (within one year)
4. EKG
5. Chest X−ray (within six months)*
6. Lab Data: CBC, ABGs, Electrolytes; DIG and Theophylline levels, if applicable (within three months)*
7. Most recent medication list

*Indicates Medicare requirement

_____ _____
Referring Physician's Signature Date/ Time

Print Physician's Name: _____

Address: _____

Telephone Number: _____