Dartmouth Health

DartmouthHitchcock Medical Center

Phone: (603) 650-2962
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

## Referral for Outpatient Pulmonary Rehabilitation Program

**Diagnosis:** _____

_____

_____

1. I agree to have my patient participate in the Dartmouth Hitchcock Medical Center Outpatient Pulmonary Rehabilitation Program.
2. I am aware that certain diagnostic data (such as PFTs, 6 minute walk, CXR, EKG, labwork, cardiopulmonary exercise test) may be required and will be requested by the medical director if not already available-within the past 12 months.
3. I agree to have my patient counseled in all areas related to pulmonary rehabilitation.
4. I agree to continue the regular care of my patient throughout their participation in the program.

Physician signature: _____ Date: _____

**Special Considerations:** _____

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