Dartmouth-Hitchcock
MEDICAL CENTER

One Medical Center Drive
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Local: (603) 653-1999
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Outpatient Pulmonary Rehabilitation Program

Physician Referral Form

Name: _____ DOB: _____

Diagnosis: _____

_____

Phone Number: _____

Address: _____

_____

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 his/her participation in the program.

Physician signature: _____ Date: _____

Phone: _____ Fax: _____

Special Considerations:

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