

Pulmonary Rehabilitation Physical & Occupational Therapy
8380 Center Drive, Suite E La Mesa, CA 91942 | Tel (619) 466-6077 | Fax (619) 466-6118

Referral Form & Current Medical History

Patient's name: _____

Date of Birth: _____ Phone No: _____

Insurance: _____ Diagnosis: _____

Does Patient require Oxygen? No Yes if yes, (LPM: _____)

Services Requested:

Pulmonary Rehabilitation: Evaluation & Treatment
(Includes **Respiratory Therapy** and **Physical Therapy Evaluations**)
Includes 6 minute walk test, Berg Balance, spirometry, pulse oximetry, endurance, pulmonary hygiene, gait training, upper/lower body strengthening, functional training in activities of daily living and self-care.
Frequency/Duration: 2-3x WK / 12 WKS or 10 WKS

Physical Therapy: Evaluation & Treatment
Treatment may include: balance/gait training, therapeutic exercise, manual therapy, upper and lower body strengthening, musculoskeletal postural and functional assessment/training, neuro-rehab, modalities.
Frequency/Duration: _____ x WK / _____ WKS

Occupational Therapy: Evaluation & Treatment
Treatment may include: therapeutic exercise, hand/shoulder/neck assessments, manual therapy, upper body strengthening, activities of daily living, self-care and modalities.
Frequency/Duration: _____ x WK / _____ WKS

Precautions/Instructions: _____

Physician's Name: _____

Physician's Signature: _____ Date: _____

PLEASE FORWARD PATIENT MEDICAL HISTORY UPON REFERRAL

 **FREE TRANSPORTION!** 

Thank you for referring to La Mesa Rehab

We look forward to working with you!