Please fax to: (360) 676-6636

Patient Name: ______________________________ **Phone:** ______________

Primary Insurance: ______________________________ **Referral Date:** ______________

Pulmonary Rehabilitation

❑ Evaluate & Treat:

- *Breathing retraining*
- *Improve breathlessness*
- *Improve tolerance for work related activities*
- *Functional testing*
- *Improve ADL function / safety / tolerance*
- *Compliance with medications*
- *Independent home exercise program*
- *Medication administration*
- *Modify risk behaviors*
- *Increase strength & endurance*

Pulmonary Services

❑ Oximetry assessment:
Overnight *or* Rest *or* Exercise *(circle one)*

❑ Spirometry: Pre, Post, Both *(circle one)*

❑ Secretion clearance & mobilization

❑ Other ______________________

PLEASE INCLUDE:

- Patient fact sheet or demographics
- Any copies of relevant office notes or history and physical
- Any required managed care referral

Thank you for your kind referral

Provider's Signature: ______________________________________

Provider's Name: ______________________________ **c.c. Report To:** ______________

Telephone: (________)______________________ **Fax:** (________)______________________

NorthStar
Medical Specialists | 1345 King Street
Bellingham, WA 98229-6223 | Tel: (360) 676-1696
Fax: (360) 676-6636 | *www.northstarmedicalspecialists.com*
contact@northstarmedicalspecialists.com