McLaren Bay Region
PULMONARY REHABILITATION EXERCISE PRESCRIPTION

Name_____Age_____

Maximum Heart Rate= 220-age_____60%_____80%_____
Karvonen Heart Rate: _____
Please include the following information with your referral
_____Physical Exam notes (dated and within 90 days of referral)
_____Pulmonary Function Test (within the last year)
_____Any labs, X rays, or Cardiac Testing that may be pertinent.
_____Patient must be Non-Smoker, or willing to quit smoking.
Patient Diagnosis_____
ICD10 Code_____

Upper Extremity Exercise: Wall Pulleys, Arm Ergometer, UBE, Arm Scifit, Overheads
Begin at _____minutes with _____workload and progress to _____minutes at _____workload.
Activity 2_____

Lower Extremity Exercise: Treadmill
Begin at _____minutes with _____workload and progress to _____minutes at _____workload.

Multi Extremity Exercise: NuStep, Recumbent bike, Rex, Schwinn Air dyne, Rower
Begin at _____minutes with _____workload and progress to _____minutes at _____workload.

Weight Equipment: Various
Begin at _____minutes with _____workload and progress to _____minutes at _____workload.

_____Respiratory Muscle Training
_____Chest Wall Manipulation
_____Specific Functional Deficits
_____Smoking Cessation

Oxygen Therapy
_____Oxygen at _____L/M and/or maintain SpO2 >90%

I certify that I have reviewed the patient's chart and that the patient is willing and capable to participate in the Pulmonary Rehabilitation Program.
Physician
Signature_____Date_____Time_____