St. Joseph Hospital
ST. JOSEPH HEALTH SYSTEM

OUTPATIENT LUNG PROGRAM

POST-OP PULMONARY / RESPIRATORY AND PHYSICAL THERAPY PRESCRIPTION

Cancer Center Building
1010 West La Veta, Suite 675
Orange, California 92868
TEL: 714-542-8002 / 714.771.8222 FAX:714.542.8003

PATIENT :	**SSN #: - -**	**D.O.B. / /**
DIAGNOSIS:	**SURGERY :**	**DATE: / /**
PHYSICIAN:	**LICENSE:**	**TEL:**

PATIENT ALLERGIES: _____

REHABILITATION TREATMENT DIAGNOSES

❑ General Muscle Weakness 728.87
❑ Abnormal Posture 781.92
❑ Difficulty Walking 719.7
❑ Other _____

RESPIRATORY TREATMENT DIAGNOSES

❑ Respiratory Distress Insufficiency Following Surgery 786.09
❑ Pulmonary Insufficiency Following Surgery 518.5
❑ Other Pulmonary Insufficiency Not Elsewhere Classified 518.82

RESPIRATORY THERAPY PRIOR TO REHABILITATION

❑ Heated Aerosol by Face Mask x 20 “
❑ CPT All Lobes After Neb Treatments
❑ Albuterol Unit Dose-hand Held With Pep Valve
❑ Other_____

_____

REHABILITATION

EVALUATION AND TREATMENTS

Lung Program Protocol Includes the Following:

Evaluation	Stretching / Warm Up Exercises	Treadmill
Functional Activities	Patient / Family Education	Home Program

PATIENT NOTES:_____
_____

PATIENT GOALS:_____

TREATMENT DURATION_____ TIMES / WEEK _____WEEKS _____VISITS

I certify that the above rehabilitation services are required and authorized, and that the patient’s plan will be reviewed every thirty days.

Physician Signature_____**Date**____/____/____

Next M.D.Visit_____/____/_____ **Time**_____