



**Lifespan Cardiovascular Institute**

Rhode Island Hospital • The Miriam Hospital  
Newport Hospital

*Delivering health with care.®*

**The Center for Cardiac Fitness at The Miriam Hospital**

208 Collyer Street, 2nd Floor, Providence, RI 02904

Phone: 401-793-5810 • Fax: 401-793-5815

**Pulmonary Rehabilitation and/or Respiratory Services**

**Referral Available in LifeChart for Lifespan Physicians Under Procedure REF5055**

PATIENT \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

INSURANCE (1) \_\_\_\_\_ ID# \_\_\_\_\_

INSURANCE (2) \_\_\_\_\_ ID# \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

ICD-10 CODE(S): \_\_\_\_\_

ONSET DATE \_\_\_\_\_

**Eligible diagnoses include:** COPD, emphysema, chronic bronchitis, sarcoidosis, pulmonary hypertension, pulmonary fibrosis, interstitial lung disease, lung cancer and effects of lung cancer surgery, lung-volume reduction surgery before and after lung transplant.

A pulmonary function test **IS REQUIRED** for entrance into the Pulmonary Rehab Program.

- Results enclosed
- It has been scheduled for DATE \_\_\_\_\_

*I agree to baseline, midpoint, and discharge 6-Minute walk test to assess the patient's functional status.*

*I consent to have my patient participate in the Center for Cardiac Fitness Pulmonary Rehabilitation Program at The Miriam Hospital.*

NAME OF PHYSICIAN (PLEASE PRINT) \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ MD SIGNATURE: \_\_\_\_\_

**For NON-LIFESPAN Physicians**

Please forward **recent office note, EKG, and PFT scores** along with this referral to:

**401-793-5815**