McLAREN FLINT
Flint, MIchigan
PULMONARY REHABILTATION

PHYSICIAN NOTIFICATION OF PATIENT EVENT

Patient Name: _____ Today's Date: _____

Patient Diagnosis: _____ Date of Birth: _____

Reason for Report:	❑ New sign/symptom ❑ Change from previous condition ❑ _____ exceeds acceptable parameters ❑ Other: _____
Point at which event occurred:	❑ Reported on arrival by patient ❑ At rest, pre-exercise ❑ During first 5 minutes of exercise ❑ After _____ minutes of exercise ❑ Mode: _____ Work intensity: _____ ❑ During rest following exercise session ❑ Other: _____
Type of Event:	❑ Chest pain; intensity on pain scale =_____ (0/10) ❑ Rhythm/EKG change (see attached session report) ❑ B/P change/abnormality ❑ Blood sugar change/abnormality ❑ Short of breath/dyspnea/abnormal oxygen saturation ❑ Other: _____
Description of Event:	

Parameter	On arrival	With event	At departure
Time			
Heart rate			
Rhythm			
Blood pressure			
Respirations/O2 sat/ Delivery Device			
Blood sugar			
Other: _____			

Description of action taken:
❑ Managed by Rehab Staff ❑ Sent to clinic/physician office ❑ Sent to Emergency Room

Report completed by:_____Rehab Staff Resp.Therapist

❑ Signed original in chart after faxing to physician ❑ Copy for review at next unit meeting

*Delivery Options: NC Nasal Cannula Pend Pendant
VM Venti Mask Other _____
NR Non rebreather

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17564 (1/15)

560b

PT.

MR.#/RM.

DR.