

Bartlett Regional Hospital
Outpatient Pulmonary Rehabilitation Program
Informed Consent

As part of my care for chronic obstructive pulmonary disease, I am enrolling in the Outpatient Pulmonary Rehabilitation Program. The purpose of this program is to:

- improve the management of my disease,
- Increase my strength and stamina,
- Help me cope with chronic lung disease, and
- Improve my ability to perform activities of daily living.

This program has been recommended to me by Dr. _____

When I enter this program, I will have a clinical evaluation. This evaluation will include:

- Pulmonary function
- tests arterial blood gases
- An exercise test with

The pulmonary staff will meet with me to plan goals for my treatment and home care.

I will attend classes 2 times per week for twelve weeks at Bartlett Regional Hospital, which will include education and supervised exercise. I may also be able to participate from home using telehealth audio or video services with the approval of my physician.

The program will include an individualized exercise prescription prepared by the pulmonary rehabilitation staff in conjunction with my physician and based on my tolerance.

The exercise prescription is designed to place a gradually increasing workload on the cardiopulmonary system and thereby improve its function.

The reaction of the cardiopulmonary system to such activity cannot be predicted with complete accuracy. Exercise may result in shortness of breath, decreased oxygen levels in the blood, chest discomfort, excessive blood pressure, and heart rate or rhythm changes.

During the program, I will be instructed as to signs and symptoms that I should report to the

While I am at Bartlett Regional Hospital emergency equipment and trained personnel are available to deal with and minimize the danger of untoward events should they occur. If I am participating in the program remotely using telehealth, I understand I must call 9-1-1 if I have a medical emergency.

My physician will be informed of my progress and I will continue to have appointments with him/her as needed.

It is my responsibility to contact my insurance company for benefit information and notify staff if coverage is not available.

I have read the foregoing and have had an opportunity to ask questions which have been answered to my satisfaction.

Date: _____

X _____
Patient's Signature

Cardiopulmonary Rehab Staff