Phone: (810) 342-5370 | **McLAREN FLINT PULMONARY REHABILITATION REFERRAL FORM** | Fax: (810) 733-6965

Name: _____ Date: _____ / _____ / _____

Address (Include city, state and zip): _____

Phone: _____

Primary Doctor: _____

Date of Birth: _____ / _____ / _____

Diagnosis: Please check one appropriate acceptable Medicare Diagnosis Code listed below.

	Code	Diagnosis
☐	J43.9	Emphysema
☐	J42	Unspecified Chronic Bronchitis
☐	J45.40	Asthma with chronic pulmonary disease without mention of status asthmaticus or acute exacebation or unspecified
☐	J44.9	Chronic airway obstruction, unspecified
☐	J47.9	Bronchiectasis
☐	J84.10	Pulmonary fibrosis
☐	J84.01	Alveolar proteinosis
☐	J84.02	Pulmonary alveolar microlitiasis
☐	J64	Pneumoconiosis, unspecified
☐	J68.4	Chronic respiratory conditions due to chemical, gases, fumes and vapors

	Code	Diagnosis
☐	J68.9	Unspecified respiratory conditions due to chemical, gases, fumes and vapors
☐	J70.1	Chronic and other pulmonary manifestations due to radiation
☐	J61	Pneumoconiosis due to asbestosis and other mineral fibers
☐	E84.9	Cystic fibrosis unspecified
☐	D86.9	Sarcoidosis unspecified
☐	J98.4	Other diseases of the lung NOS, Restrictive Lung Disease (RLD)
☐	Z94.2	Lung transplant status

Please include the following *required* information with your referral:

1. **Medical history and office visit notes.**
2. **Pulmonary function test (dictation and number graphs)**
3. **If you do not have a current PFT, we will perform test if you check here:** ☐
4. **Reports from chest x-rays / EKG / Echo / Stress tests.**
5. **Copies of ALL insurance cards; front and back please.**

Plan of Treatment:

1. Training and education of disease process.
2. Physical Therapy Evaluation and Treatment as needed
3. Exercise
   - Per routine protocol (60-85% maximum heart rate)
   - Low level protocol (HR increase of 20-30 beats)
   - Other: _____ Target HR: _____

I certify that:

1. A physical exam has been performed within the last 90 days.
2. The patient is capable and willing to participate in the plan of care.
3. The patient has quit smoking or is willing to participate in smoking cessation activities prior to or during the course of Pulmonary Rehab services.

I will continue the regular medical care of my patient throughout his/her participation in the program.

Physician Signature: _____ Date: _____ / _____ / _____

Phone: _____ Fax: _____

PULMONARY REHABILITATION REFERRAL FORM

M-17549 (9/16)

660B

PT.

MR.#/RM.

DR.