

Pulmonary Rehabilitation Referral
Form 364 White Oak Street
P.O. Box 1048
Asheboro, NC 27204-1048
Phone: (336) 633-7752
Fax: (336) 633-7750

Date: _____

Referring Practitioner Signature: _____

Patient Name: _____

Printed Name: _____
Date _____ Time _____

DOB: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Pulmonary Diagnosis: (Please provide ICD code of diagnosis) - PLEASE CIRCLE APPROPRIATE DIAGNOSIS

_____ COPD/Emphysema -- Gold Standard Classification _____

_____ Asthma

_____ Chronic Bronchitis

_____ CHF/Congestive Heart Failure

_____ Cystic Fibrosis

_____ Pulmonary Fibrosis

_____ Heart Failure NYHA class

_____ other: _____

Medical Records required for admittance and chart completion

1. History and Physical
2. Discharge summary from most recent hospitalization
3. Labs: lipid profile, CBC, Chemistry
4. Most recent office note
5. Medication list
6. Cardiac testing last 12 months
7. Pulmonary function study

The Medical Director will order required labs/pulmonary test for the participant if not available on admission.

Pulmonary Function Study Lipid Profile

Medical Director: _____
Date _____ Time _____

Printed Medical Director Name: _____

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PRREFERRALFORM



Original 07/2016
Pulmonary Rehabilitation
Referral Form