



Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: M F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Order Information - Pulmonary Rehabilitation

Outpatient Pulmonary Rehabilitation – Phase II (CPT G0424, G0239)

Diagnosis (please check all that apply):

Note: Medicare will ONLY cover the following diagnoses.

- | | | |
|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> COPD | <input type="checkbox"/> Asthma | <input type="checkbox"/> Interstitial Lung Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Pulmonary Fibrosis |
| <input type="checkbox"/> Bronchitis | | |

Other (please specify): _____

ICD-CM Codes for Selected Diagnosis and Other: _____

Please include the following information with this referral:

- Pulmonary Rehabilitation Order Form (This Sheet)
- Medical History/Physical and/or Discharge Summary
- Most Recent PFT Results
- Current Medication List

The above patient may participate in **Outpatient Pulmonary Rehabilitation** consisting of monitored exercise and personal risk modification instruction for a minimum of six weeks, 2-3 times per week.

Staff will:

1. Evaluate pulmonary history and current status.
2. Perform the Six-Minute Walk Test with pulse oximetry to evaluate exercise tolerance.
3. Titrate oxygen during exercise to maintain oxygen saturation of at least 88% or _____%.
4. Devise exercise prescription for supervised exercise program and home exercise program according to the daily, individual needs of the patient.
5. Provide patient with instruction on:
 - a. Breathing retraining and bronchial hygiene
 - b. Respiratory system anatomy and physiology
 - c. Conditioning exercises
 - d. Medication use
 - e. Nutrition
 - f. Panic control, stress management, and coping techniques
 - g. Maximizing one's efforts, simplifying daily activities
 - h. Proper use of equipment including oxygen

Other needs identified by the physician: _____

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License #: _____
 Physician Address: _____ Phone #: _____ Fax #: _____
 I hereby certify that the services indicated in the above order form are medically necessary.
 Physician Signature: _____ Date: _____ Time: _____