TOWER HEALTH
Advancing Health. Transforming Lives.

Pulmonary Rehabilitation Program/Outpatient Respiratory Care Services Exercise Referral Form

PARTICIPANT NAME: _____ DOB: _____ DATE: _____
PHYSICIAN: _____ PHYSICIAN'S PHONE #: _____
□= Prescriber's option must check off to order. ☑= automatically initiated unless crossed out.
TO BE COMPLETED BY PHYSICIAN: PLEASE FILL OUT ITEMS 1 - 6 COMPLETELY.
E-mail: PHPulmonaryRehab@Towerhealth.org Fax To:

ICD-10 Code and Specific Date (00/00/0000) Must be included with diagnosis

□ **Admit to Pulmonary Rehab Program (G0424) – 36 sessions**

Diagnosis	**ICD-10 Code**	**Date**
□ Chronic Obstructive Pulmonary Disease	J44.9	____/_____/_____
□ Chronic Bronchitis	J41-J42	____/_____/_____
□ Emphysema	J43	/ /

□ **Admit to Outpatient Respiratory Care Services (G0239, G0238, G0237) – 36 sessions**

Diagnosis	**ICD-10 Code**	**Date**
□ Pulmonary Fibrosis Unspecified	J84.1	____/_____/_____
□ Pulmonary Fibrosis Interstitial	J84.89	____/_____/_____
□ Asbestosis	J61	____/_____/_____
□ Lung Transplant	Z94.2	____/_____/_____
□ Other Lung Disease	J98.4	____/_____/_____
□ _____	_____	____/_____/_____

2. **Exercise Prescription**: (Boxes **MUST** be checked)
□Per protocol □Special recommendations: _____
3. **Education**: (Boxes **MUST** be checked)
□ Per protocol □Special recommendations: _____
4. **Counseling, Behavior Changes, Psychosocial Intervention, Diet and Nutrition**: (Boxes **MUST** be checked)
□Per protocol □Special recommendations: _____
5. **Participant is**: □TOBACCO FREE □NEEDS TOBACCO CESSATION COUNSELING
□ on the following smoking cessation regimen: _____
6. **Participant is prescribed oxygen therapy**.
□ NO □ YES: _____ L/min □ continuously □at night □ other: _____

☑ **Implement the Management of Emergency Policy PRN**
(If crossed out, please specify interventions to be implemented:
_____

Cardiopulmonary Stress Test 94618: (6 Minute Walk)
(Cross out if patient unable to perform CPX) Unless already completed within the last 12 months, date of results: _____ fax results.

☑ **Complete Pulmonary Function Test 94010, 94060, 94727, 94729**: with bronchodilator, unless otherwise indicated
Unless already completed within the last 12 months, date of results: _____ fax results.

☑ **12-lead EKG G8704**:
Unless already completed within the last 12 months, date of results: _____ fax results.

☐ **Cardiovascular Stress Test 93015:** Optional if patient has known cardiac history.

Physician Signature: _____ **Date:** _____ **Print name:** _____

(Revised 3/2018)