**Pulmonary Rehab Referral Form**

25 Jacobs Gulch, Kellogg, ID 83837

208-784-1221, ext. 390 ⬩ 208-786-8400 fax

Date Referring Practitioner Signature

Patient Name Printed Name

DOB Phone

Patient Phone Fax

Pulmonary Diagnosis (Please provide ICD code of diagnosis):

Diagnosis #1 ICD-10 Code

Diagnosis #2 ICD-10 Code

Diagnosis #3 ICD-10 Code

Date of last PFT

**Pulmonary Rehabilitation Outpatient Program**

I authorize the Pulmonary Rehabilitation Department to:

* Schedule full PFT (if not done within the last 3 months)
* Initiate/titrate supplemental oxygen PRN during exercise to maintain SpO2 level ≥ 88%
* Perform 6 minute walk test pre-program, as well as monthly
* Develop individualized treatment plan/exercise for review and approval by the ordering physician, initially and Q30 days until discharge

Medical records required for admittance and chart completion:

1. History and physical
2. Insurance information
3. Recent lab results
4. Most recent office notes
5. Medication list
6. Last PFT results

*I hereby certify that the above patient is medically able to participate in Pulmonary Rehabilitation.*

*I am also aware and agree that I must physically visit with my patient every 30 days while in the program.*

**PLEASE FAX COMPLETED FORM TO 208-786-8400.**