Shoshone MEDICAL CENTER
25 Jacobs Gulch, Kellogg, Idaho, 83837 * 208-784-1221

Pulmonary Rehabilitation - Referral Form

Version No.: 3

Patient Name_____

Patient DOB _____ Patient Phone_____

Pulmonary Diagnosis:

☐	J44.9	COPD/ Chronic bronchitis (obstructive chronic bronchitis)
☐	J43.9	Emphysema
☐	E88.01	Alpha $_1$ Antitrypsin Deficiency (a_1AT)
☐	J45.909	Asthma and asthmatic bronchitis
☐	J47.9	Bronchiectasis
☐	E84.0	Cystic fibrosis
☐	J42	Bronchiolitis Obliterans
☐	J84.112	Pulmonary Fibrosis
☐	J96.10	Chronic Respiratory Failure
☐		Other _____

Pulmonary Rehabilitation Outpatient Program

I authorize the Pulmonary Rehabilitation Department to:

- Schedule full PFT (if not done within the last 6 months). May defer if previous PFT shows COPD (GOLD II, III, or IV).
- Initiate/titrate supplemental oxygen PRN during exercise to maintain SpO_2 level ≥ 88%
- Perform 6-minute walk test on initial evaluation and at discharge
- Develop individualized treatment plan/exercise for review and approval by the ordering physician, initially and Q30 days until discharge
- Do Alpha 1 antitrypsin testing per ATS recommendations

Medical records required for admittance and chart completion:

History and physical, Insurance information, Most recent office notes, Medication list, Last PFT results (if available)

☐Prior Authorization done #_____ ☐ No Prior Authorization needed

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

HCP Printed Name_____ Signature_____

Date _____ Phone _____ FAX _____

PLEASE FAX COMPLETED FORM TO 208-786-8400