Garnet Health MEDICAL CENTER

Outpatient Pulmonary Rehabilitation

Please print all information.

Patient Name: ______________________________ **Date of Birth:** ____ / ____ / ______

Contact Number: ________________________

Insurance Carrier: ____________________ **Member Identification Number:** ________________________

Referring Provider: ______________________________

Contact Number: ________________________ **Fax Number:** ________________________

Reason for Referral and impact: (Please check all that apply)

- ☐ Dyspnea, fatigue and symptomatic
- ☐ Impaired health quality of life
- ☐ Decrease functional status
- ☐ Decrease occupational status
- ☐ Difficulty in performing ADLs
- ☐ Difficulty with adherence to medical plan
- ☐ Psychosocial issues directly related to respiratory illness
- ☐ Nutritionally depleted due to increased work of breathing
- ☐ Gas exchange abnormalities including hypoxia
- ☐ Tobacco addiction _______ppd________ yrs
- ☐ Increased use of medical resources:
  - #pulmonary inpatient admissions in the previous year ________
  - # pulmonary exacerbations in the previous six months ________
  - # emergency room visits in the previous six months ________

Questions or more information?

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ICD-10 Code/Diagnosis: ______________________________

Comments and additional information: ____

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When submitting the outpatient pulmonary rehabilitation referral sheet, please be sure to include the following items with your completed referral sheet:

- **Most recent Pulmonary Function Test results or most recent Spirometry results**
- **Office Visit Note(s) indicating pulmonary condition and need for pulmonary rehabilitation consultation**
- **Contact information for patient's PCP, cardiologist, or any other practitioner who may add to this care**

Signature of Referring Provider: ________________________ **Date:** ____ / ____ / ______