EMORY HEALTHCARE

PS-1051

Pulmonary Rehabilitation Order Form
FAX orders to: 404.501.7689
Phone: 404.501.7155

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.

❑ COPD ❑ Asthma ❑ Interstitial Lung Disease
❑ Emphysema ❑ Sarcoidosis ❑ Pulmonary Fibrosis
❑ 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:** _____