



## PULMONARY REHABILITATION PROGRAM- PHYSICIAN REFERRAL

1.) Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Patient Telephone Number: \_\_\_\_\_

**2.) Please circle all diagnoses w/ ICD-10 codes that apply:**

COPD: ICD-10: \_\_\_\_\_

Pulm Fibrosis: ICD-10: \_\_\_\_\_

Pulm HTM: ICD-10: \_\_\_\_\_

Other Pulmonary  
Dx: \_\_\_\_\_  
ICD-10: \_\_\_\_\_

Other Pulmonary  
Dx: \_\_\_\_\_  
ICD-10: \_\_\_\_\_

\*please send most recent clinic notes with this referral\*

**3.) GOLD STAGE (circle one)**

**\*\*MUST MATCH PFT RESULTS\*\***

**Stage 1:** Mild COPD  
(FEV/FVC < 70%)  
( FEV ≥ 80% predicted)

**Stage 2:** Moderate COPD  
(FEV/FVC < 70%)  
(50% < FEV < 80% predicted)

**Stage 3:** Severe COPD  
(FEV/FVC < 70%)  
(30% < FEV < 50% predicted)

**Stage 4:** Very Severe COPD  
(FEV/FVC < 70%)  
(FEV < 30% predicted)

**4.) PFT's** (Prefer PFT be completed within 12 months of entry into our pulmonary rehab program). (please circle one box for PFTs)

**PFTs** performed in our office. To be sent with referral

**Administer PFTs** at Airobics Pulmonary Rehab Center

Our Pulmonary rehab program will administer a 6 minute walk test in your patients first visit. There is no additional charge for this test; it is part of their Pulmonary rehab intake appointment.

**5.) SPECIAL INSTRUCTIONS or LIMITATIONS:**

\_\_\_\_\_  
\_\_\_\_\_

**6.) Referring Physician Name (Print):** \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Office Contact: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_

**7.) Please fax referral, recent clinic notes, and any PFT and 6MWT test results.**

*Cardiac & Pulmonary Rehabilitation Services Available*

**PALOS HEIGHTS**

Tel: 708.897.8666  
Fax: 708.926.2343  
13450 S. Ridgeland Ave | Palos Heights, IL 60463

**CHICAGO**

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Fax: 872.703.3936  
10224 S Kedzie Ave | Evergreen Park, IL 60805 |

**HARVEY**

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