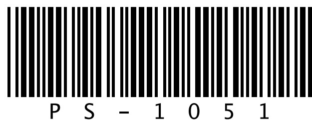
EMORY
DECATUR
HOSPITAL



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
❑ Emphysema
❑ Bronchitis
❑ Asthma
❑ Sarcoidosis
❑ Interstitial Lung Disease
❑ Pulmonary Fibrosis

❑ 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:** __________________