McLaren Business Products

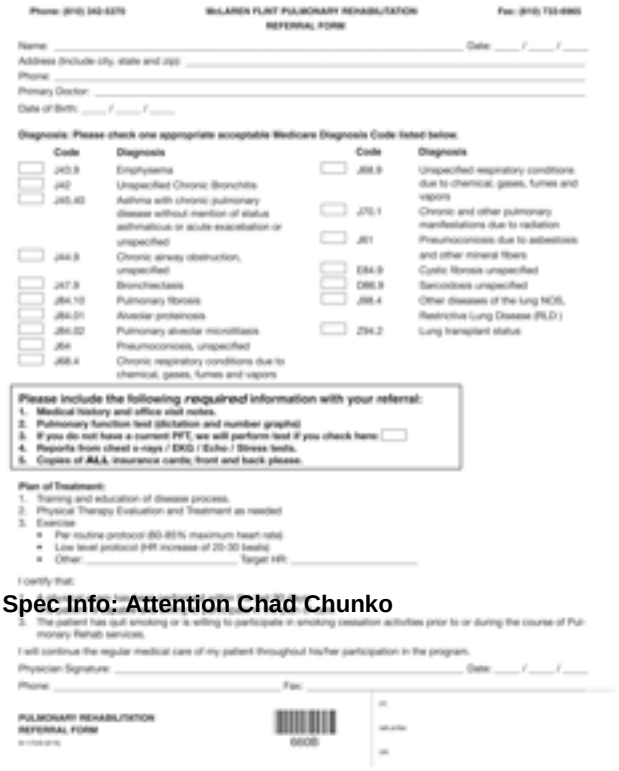
McLaren Print System Order

Order No: 62455
Order Date: 2021-05-17
User: chad chunko
Phone: 8103422235

Ship Location: Mclaren Flint wound care
G3200 Beecher road Suite O2
flint, MI 48532
Forms
Quantity: 500
Paragon Dept No: 27105
Dept Name: Mclaren Flint pulmonary rehab
Company Number: 60

Order Total Price: 21.75

Item Number: M-17549
Item Description: Pulmonary Rehabilitation Referral Form
Revision Date: 9/2016
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: Padded (25 Sheets Per Pad)
Drill: None
Misc Info:



Phone: (810) 342-5370 McLAREN FLINT PULMONARY REHABILITATION REFERRAL FORM Fax: (810) 733-6965

Name: _____ Date: ____ / ____ / ____
Address (include city, state and zip): _____
Phone: _____
Primary Doctor: _____
Date of Birth: ____ / ____ / ____

Diagnosis: Please check one appropriate acceptable Medicare Diagnosis Code listed below.

	Code	Diagnosis		Code	Diagnosis
☐	J43.9	Emphysema	☐	J68.9	Unspecified respiratory conditions due to chemical, gases, fumes and vapors
☐	J42	Unspecified Chronic Bronchitis			
☐	J45.40	Asthma with chronic pulmonary disease without mention of status asthmaticus or acute exacerbation or unspecified	☐	J70.1	Chronic and other pulmonary manifestations due to radiation
			☐	J61	Pneumoconiosis due to asbestosis and other mineral fibers
☐	J44.9	Chronic airway obstruction, unspecified	☐	E84.9	Cystic fibrosis unspecified
☐	J47.9	Bronchiectasis	☐	D86.9	Sarcoidosis unspecified
☐	J84.10	Pulmonary fibrosis	☐	J98.4	Other diseases of the lung NOS, Restrictive Lung Disease (RLD)
☐	J84.01	Alveolar proteinosis			
☐	J84.02	Pulmonary alveolar microlithiasis	☐	Z94.2	Lung transplant status
☐	J64	Pneumoconiosis, unspecified			
☐	J68.4	Chronic respiratory conditions due to chemical, gases, fumes and vapors			

Please include the following *required* information with your referral:
1. **Medical history and office visit notes.**
2. **Pulmonary function test (dictation and number graphs)**
3. **If you do not have a current PFT, we will perform test if you check here:** ☐
4. **Reports from chest x-rays / EKG / Echo / Stress tests.**
5. **Copies of ALL insurance cards; front and back please.**

Plan of Treatment:
1. Training and education of disease process.
2. Physical Therapy Evaluation and Treatment as needed
3. Exercise
   - Per routine protocol (60-85% maximum heart rate)
   - Low level protocol (HR increase of 20-30 beats)
   - Other: _____ Target HR: _____

I certify that:

3. The patient has quit smoking or is willing to participate in smoking cessation activities prior to or during the course of Pulmonary Rehab services.

I will continue the regular medical care of my patient throughout his/her participation in the program.

Physician Signature: _____ Date: ____ / ____ / ____
Phone: _____ Fax: _____

PULMONARY REHABILITATION REFERRAL FORM

6608

Spec Info: Attention Chad Chunko