Use Ballpoint Pen Only

Pulmonary Rehabilitation Referral
Form 364 White Oak Street
P.O. Box 1048
Asheboro, NC 27204-1048
Phone: **(336) 633-7752**
Fax: **(336) 633-7750**

Date: _____ Referring Practitioner Signature: _____

Patient Name: _____ Printed Name: _____

Date Time

DOB: _____ Address: _____

Address: _____ _____

_____ Phone: _____

Phone: _____ Fax: _____

Pulmonary Diagnosis: (Please provide ICD code of diagnosis) - PLEASE CIRCLE APPROPRIATE DIAGNOSIS

_____ COPD/Emphysema -- Gold Standard Classification _____
_____ Asthma
_____ Chronic Bronchitis
_____ CHF/Congestive Heart Failure
_____ Cystic Fibrosis
_____ Pulmonary Fibrosis
_____ Heart Failure NYHA class
_____ other:_____

Medical Records required for admittance and chart completion

1. History and Physical
2. Discharge summary from most recent hospitalization
3. Labs: lipid profile, CBC, Chemistry
4. Most recent office note
5. Medication list
6. Cardiac testing last 12 months
7. Pulmonary function study

The Medical Director will order required labs/pulmonary test for the participant if not available on admission.
☐ Pulmonary Function Study ☐ Lipid Profile

Medical Director: _____
Date **Time**

Printed Medical Director Name: _____