Goshen Hospital

Cardiopulmonary Rehab Services
1855 South Main St., Suite B
Goshen, IN 46526
Office 574-364-2587 Fax 574-364-2531

Patient Name _____	Ordering Physician Signature _____
Date of Birth _____Social Security _____	Ordering Physician _____
Address _____	
City _____State _____Zip _____	Primary Care Physician _____
Telephone # _____	Send Copy To _____
	Fax Results To _____
Primary Insurance _____	
Primary Policy # _____Group # _____	Diagnosis #1 _____ICD-10 Code _____
	Diagnosis #2 _____ICD-10 Code _____
Secondary Insurance _____	Diagnosis #3 _____ICD-10 Code _____
Secondary Policy # _____Group # _____	Diagnosis #4 _____ICD-10 Code _____

Pulmonary Rehabilitation Referral Form

Date of referral: _____

❑ Pulmonary Rehab Outpatient Program (maximum of 36 sessions, 3/week)

For required safety and admission qualifications, I authorize the following:

- Full PFT (if not done within the last 3 months).
- 12 lead EKG (if not done within the last 6 months).
  - ✓ Diagnosis #1 _____ICD-10 Code _____
  - ✓ Diagnosis #2 _____ICD-10 Code _____
  - ✓ Diagnosis #3 _____ICD-10 Code _____
- Initiate/titrate supplemental oxygen PRN during exercise.
- 6 Minute Walk Test pre and post program.
- Rehab staff to develop Individualized Treatment Plan/Exercise Rx for Medical Director review/approval, initially and Q30 days until discharge.

❑ Other: _____

I hereby certify that the above patient is medically able to participate in Pulmonary Rehab.

PLEASE FAX COMPLETED FORM TO
574-364-2531