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 Program (up to 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).
- Initiate/titrate supplemental oxygen PRN during exercise.
- Rehab staff to develop Individualized Treatment Plan/Exercise Rx for Medical Director review/approval, initially and Q30 days until discharge.

☐ Post COVID-19 Pulmonary Rehab Program (up to 36 sessions, 3/week)

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

- 12 lead EKG (if not done within the last 6 months).
- Initiate/titrate supplemental oxygen PRN during exercise.
- Rehab staff to develop Individualized Treatment Plan/Exercise Rx for Medical Director review/approval, initially and Q30 days until discharge.

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

PLEASE FAX COMPLETED FORM TO 574-364-2531