UNIVERSITY of MARYLAND
UPPER CHESAPEAKE MEDICAL CENTER
MEMBER OF UPPER CHESAPEAKE HEALTH

Pulmonary Rehabilitation Program/Outpatient Respiratory Care Services
Exercise Referral Form

PARTICIPANT NAME: ____________________________ DOB: _____________ DATE: _____________

PHYSICIAN: ____________________________ PHYSICIAN'S PHONE #: ________________________

☐ = Prescriber's option *must* check off to order. ☑ and orders without checkboxes = *automatically* initiated unless crossed out

TO BE COMPLETED BY PHYSICIAN: PLEASE FILL OUT ITEMS 1 - 6 COMPLETELY

Fax to: 443-643-3731

1. **ICD-10 Code and Specific Date (00/00/0000) *Must* be included with diagnosis**
   (COPD is the only diagnosis that qualifies for Pulmonary Rehab, all other diagnoses may qualify for Outpatient Respiratory Care Services. Please check the appropriate box based on diagnosis)

☐ Admit to Pulmonary Rehab Program (G0424) – 36 sessions

Diagnosis	ICD-10 Code	Date
☐ Chronic Obstruct Pulm. Disease	J44.9	____/_____/______
☐ Chronic Bronchitis	J41-J42	____/_____/_______
☐ Emphysema	J43	____/_____/_______

☐ Admit to Outpatient Respiratory Care Services (G0239, G0238, G0237) – 36 sessions

Diagnosis	ICD-10 Code	Date
☐ Pulmonary Fibrosis Unspecified	J84.1	____/_____/_______
☐ Pulmonary Fibrosis Interstitial	J84.89	____/_____/_______
☐ Asbestosis	J61	____/_____/______
☐ Lung replaced by transplant	Z94.2	____/_____/______
☐ Other lung disease	J98.4	____/_____/______
☐ _______________________	_____	____/_____/______

2. **Exercise Prescription:** (Boxes **MUST** be checked)
   ☐ Per protocol ☐ Special recommendations: ___________________________________
3. **Education:** (Boxes **MUST** be checked)
   ☐ Per protocol ☐ Special recommendations: ___________________________________
4. **Counseling, Behavior Changes, Psychosocial Intervention:** (Boxes **MUST** be checked)
   ☐ Per protocol ☐ Special recommendations: ___________________________________
5. **Participant is**: ☐ TOBACCO FREE
   ☐ on the following smoking cessation regimen: ______________________________________
6. **Participant is prescribed oxygen therapy.**
   ☐ NO ☐ YES: _______ L/min ☐ continuously ☐ at night ☐ other: __________________

☑ Implement the Management of Emergency Policy PRN (chest pain, hypo and hyperglycemia, arrest, arrhythmias)
If crossed out, please specify interventions to be implemented:
____
____

☑ Complete Pulmonary Function Test: with bronchodilator, unless otherwise indicated

☑ 12-lead EKG
Unless already completed within the last 12 months, date of results: _______________

Physician Signature: ____ **Date:** ________________

Please print name: ____