Home Rehabilitation Network

***Fax to: 410-871-4022***

## Telemedicine Pulmonary Rehabilitation Program
## REFERRAL FORM

PARTICIPANT NAME: _____ DOB: _____

PHONE:_____

EMAIL:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

**TO BE COMPLETED BY PHYSICIAN: PLEASE FILL OUT ITEMS 1 - 3**

1. **ICD-10 Code MUST be included with diagnosis (Please check the appropriate box)**

**☐ Admit to Pulmonary Rehab Program – 36 sessions**

| *Diagnosis* | ICD-10 Code |
|---|---|
| ☐ COPD | J44.9 |
| ☐ Chronic Bronchitis | J42 |
| ☐ Emphysema | J43.9 |
| ☐ Bronchiectasis | J47.9 |
| ☐ Pulmonary Fibrosis | J84.10 |
| ☐ Cystic Fibrosis | E84.9 |
| ☐ Asthma | J45.909 |
| ☐ Lung Transplant Status | Z94.2 |
| ☐ Aftercare Following Lung Transplant | Z48.24 |
| ☐ Post COVID-19 Condition, Unspecified | U09.9 |
| ☐ Post COVID-19 Pneumonia | J12.82 |
| ☐ Other Lung Disease/Cancer | _____ |

**** PLEASE SEND A COPY OF THE MOST RECENT PFT AND OFFICE NOTE WITH YOUR REFERRAL**

2. **Participant is: ☐ TOBACCO FREE**
   ☐ on the following smoking cessation regimen: _____

3. **Participant is prescribed oxygen therapy.**

   ☐ NO ☐ YES:_____L/min ☐ continuously ☐ at night ☐ other: _____

**Physician Signature: _____**

Please print name: _____

PHONE #: _____

FAX #: _____