GIRARD Medical Center

Outpatient Pulmonary Rehab
Phone: 620-724-5126
Fax: 620-724-5127

Patient Information: **Date:**

Patient Name: _____ Date of Birth: _____

Address: _____
(City) (State) (Zip Code)

Phone: _____

Patient SS#:_____ Sex: M F

Diagnosis:

☐ J44.9 COPD Stage:_____ FEV1/FVC:_____ FEV1:_____% predicted

Stage II	Moderate COPD	FEV1/FVC<0.70	FEV1 50-79% predicted
Stage III	Severe COPD	FEV1/FVC<0.70	FEV1 30-49% predicted
Stage IV	Very Severe COPD	FEV1/FVC<0.70	FEV1 <30% predicted, or <50% predicted with chronic respiratory failure present*

☐ Interstitial Lung Disease ☐ Pulmonary Fibrosis ☐ Cystic Fibrosis ☐ Pre Lung Transplant ☐ Post Lung Transplant

Secondary Diagnosis:

☐ Hypertension ☐ Diabetes ☐ Congestive Heart Failure

Social History:

Tobacco: ☐ Current ☐ Quit ☐ Never Packs per day:_____

Type: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Smokeless Tobacco

Physician Referral:

☐ **I have examined the patient listed above and determined that his/her admission into the Pulmonary Rehabilitation Program is medically necessary.**

Physician's Name (please print):_____

Physician's Signature:_____ Date:_____ Time:_____

Office Phone#: _____ Office Fax#:_____

Please fax copy of PFT results, medical history, face sheet, last progress note, and medication list to 620-724-5127.