



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.