University Hospitals
Harrington Heart & Vascular Institute

Pulmonary Rehabilitation Physician Referral Form

Patient Name: _____ MRN: _____ Phone # _____

Referring Diagnosis: (please check the reverse side for specific ICD-9 codes)
Based on guidelines from the Center for Medicare & Medicaid Services (CMS), the following diagnostic criteria and/or ICD-9 codes on the reverse side are covered when referring patients to the Phase II Pulmonary Rehabilitation Program:

Diagnosis: Check appropriate ICD-9 code(s):
____ 496.0 COPD, not elsewhere classified ____ 416 Primary pulmonary hypertension
____ 493.20 Chronic obstructive asthma unspecified ____ 135 Sarcoidosis
____ 494 Bronchiectasis without acute exacerbation ____ 492.8 Other Emphysema
____ Other Diagnosis(s): _____

See reverse side for additional ICD-9 codes

I authorize the Pulmonary Rehabilitation Department to:

- Schedule a functional assessment either a six minute walk and/or symptom limited cardiopulmonary graded exercise test prior to starting pulmonary rehabilitation to help formulate an exercise prescription.
- Schedule a Pulmonary Function Test (PFT), including DLCO, FVC and FVC1, *if not performed within the last 3 months* (per Medicare requirements) of initiating Pulmonary Rehabilitation.
- For patients already on oxygen therapy, allow licensed staff to titrate supplemental oxygen, in order to keep the SP02 level ≥ 88% during the exercise session.
- Allow participation in group/individual counseling education sessions.
- Allow the rehabilitation staff to develop an Individualized Treatment Plan (ITP) and Exercise Prescription for review and approval by the medical director prior to the patient starting rehabilitation

_____ Establish your own ITP and exercise prescription you want your patient to follow (check box and document recommendations below).

_____

_____

Please forward a copy of the patient's last physical exam within the last 3 months.

I consent to have my patient participate in the pulmonary rehabilitation program. I will continue regular medical care of my patient throughout his/her participation in the program. I agree to allow my patient to participate in the outpatient (phase III) pulmonary rehabilitation program after completion of the phase II program.

Name of Physician (please print) _____

Date: _____ MD/DO Signature: _____

Any questions, please contact Dr. Hugo Montenegro @ (216) 844-8489 or Bob Rosneck @ (216) 983-4903 or e-mail: Robert.Rosneck@UHhospitals.org. Please fax referral and completed forms to**:**
UH Case Medical Center at (216) 844-2249 or UH Chagrin Highlands Health Center at (216) 201-5134

rev2/12

ICD-9 Codes That Support Pulmonary Rehabilitation

135	Sarcoidosis
277	Cystic Fibrosis without meconium ileus
277.02	Cystic Fibrosis with pulmonary manifestations
416	Primary pulmonary hypertension
491.1	Simple chronic bronchitis
491.20.1	Obstructive chronic bronchitis without acute exacerbation
491.8	Other chronic bronchitis
492.8.1	Other Emphysema
493.20	Chronic Obstructive Asthma unspecified
493.82	Cough-variant asthma
494.0	Bronchiectasis without acute exacerbation
496.0	Chronic airway obstruction not elsewhere classified (COPD)
500	Coal workers' pneumoconiosis
501	Asbestosis
502	Pneumoconiosis due to other silica or silicates
503	Pneumoconiosis due to other inorganic dust
504	Pneumonopathy due to inhalation of other dust
505	Pneumoconiosis unspecified
506.4	Chronic respiratory conditions due to fumes and vapors
506.9	Unspecified respiratory conditions due to fumes and vapors
508.1	Chronic and other pulmonary manifestations due to radiation
515	Postinflammatory pulmonary fibrosis
516	Pulmonary alveolar proteinosis Pulmonary alveolar microlithiasis Idiopathic fibrosing alveolitis
516.8	Other specified alveolar and parietoalveolar pneumonopathies
518.89	Other diseases of lung not elsewhere classified