Telemedicine Pulmonary Rehabilitation

REFERRAL FORM

Fax to:
410-871-4022

PATIENT NAME: _____ DOB: _____

PHONE: _____

EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

PULMONARY DIAGNOSIS:

- ☐ COPD/Emphysema
- ☐ COPD/ Asthma Overlap Syndrome
- ☐ Chronic Respiratory Failure
- ☐ Cystic Fibrosis
- ☐ Lung Transplant Status
- ☐ Post COVID-19 Condition, Unspecified
- ☐ Post COVID-19 Pneumonia
- ☐ Chronic Bronchitis
- ☐ Bronchiectasis
- ☐ Pulmonary Fibrosis
- ☐ Interstitial Lung Disease
- ☐ Aftercare Following Lung Transplant
- ☐ Other Lung Disease / Cancer

PROVIDER SIGNATURE: _____

Please Print Name: _____

PHONE #: _____

FAX #: _____