Home Rehab Network

Online Pulmonary Rehab Referral Form

Patient Information

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
- ☐ Lung Transplant Status
- ☐ Aftercare Following Lung Transplant
- ☐ Post COVID-19 Condition, Unspecified
- ☐ Post COVID-19 Pneumonia
- ☐ Chronic Bronchitis
- ☐ Bronchiectasis
- ☐ Pulmonary Fibrosis
- ☐ Interstitial Lung Disease
- ☐ Cystic Fibrosis
- ☐ Other Lung Disease / Cancer

Other: _____

Patient Status with Home Rehab Network

- ☐ New Patient Referral
- ☐ Continuation of pulmonary rehab based on medical necessity

Provider Information

Provider Signature: _____

Please Print Name: _____

Phone Number: _____

Fax Number: _____

Email: _____

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

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