Conway Medical Center

Pulmonary Rehabilitation Program

Outpatient Referral Order

2369 Cypress Circle
Conway, SC 29526
Phone: (843) 347-8153
Fax: (843) 347-1536 or (843) 234-8905

Patient Name: ____________________________

Address: ________________________________

____

Phone: _________________________________

Age: _____ Sex: _____ DOB: ___________

COPD diagnosis, based on POST BRONCHODILATOR FEV1 results:

_____ Moderate COPD FEV1 / FVC < 0.70 **(FEV1 50 – 79% of normal)**

____ Severe COPD FEV1 / FVC < 0.70 **(FEV1 30 – 49% of normal)**

____ Very Severe COPD FEV1 / FVC < 0.70 **(FEV1 less than 30% of normal)**

NON COPD – Outpatient Respiratory Therapy; for diagnoses other than COPD:

____ Sarcoidosis ____ Interstitial Fibrosis ____ Pulmonary Hypertension

____ Cystic Fibrosis ____ Lung Cancer ____ Other ___________________

Please check the program appropriate for your patient:

____ Phase 2 (Pulse Oximetry monitoring) 2 visits per week up to 36 sessions

____ Phase 3 (Maintenance Self Pay; Intermittent Pulse Oximetry monitoring)

Pulmonary Function testing, within 12 months, is required by Medicare and recommended by American Association of Cardiovascular and Pulmonary Rehabilitation.

____ I will forward the results of a recent Pulmonary Function Test, including Post Bronchodilator FEV1.

____ I will forward the office visit note including medication list, signed and dated within 3 months of this referral.

Please enroll my patient in the Pulmonary Rehabilitation Program.

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Physician Signature Physician Name – Printed Date

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