McLaren Flint Pulmonary Rehabilitation Referral

Phone (810) 342-5370 • Fax (810) 733-6965
G3230 Beecher Road • Lower Level • Flint, MI 48532

Patient Name: _____

Address: _____

Phone: _____ DOB ____/____/____

PCP: _____

Diagnosis: Please check one appropriate acceptable Medicare diagnosis code listed below.

Code	Diagnosis (COPD) - CPT 94625
❑ J42	Chronic bronchitis
❑ J43.0	Unilateral pulmonary emphysema (MacLeod's syndrome)
❑ J43.1	Panlobular emphysema
❑ J43.2	Centrilobular emphysema
❑ J43.8	Other emphysema
❑ J44.9	Chronic obstructive pulmonary disease, unspecified

❑ Other (please include ICD 10 diagnosis):

_____

_____

_____

❑ Covid 19 diagnosis

- Primary ICD10: R06.09 - COVID Long Hauler – Dyspnea
  - SOB must be greater than 4 wks in duration
- Secondary ICD10: U09.9 – Post COVID-19 condition

Code	Diagnosis (Respiratory Services) CPTs: G0237, G0238
❑ J45.909	Unspecified asthma, uncomplicated
❑ J47.9	Bronchiectasis
❑ E84.0	Cystic fibrosis with pulmonary manifestations
❑ J84.1	Pulmonary fibrosis, unspecified
❑ D86.0	Sarcoidosis of lung
❑ J84.115	Respiratory bronchiolitis interstitial lung disease
❑ T94.2	Lung transplant
❑ J98.6	Diaphragm disorders (ie paralysis)
❑ I27.0	Primary pulmonary hypertension
❑ M41.9	Scoliosis
❑ M41.20	Kyphoscoliosis
❑ J84.1	Interstitial lung disease

Please include the following *required* information with your referral:

1. **Recent history and physical note**
2. **Pulmonary function test (dictation and number graphs)**
3. **If you do not have a current PFT, we will perform test if you check here: ❑**
4. **Reports from chest x-rays / EKG / Echo / Stress tests.**
5. **Copies of ALL insurance cards; front and back please.**

Plan of Treatment:

1. Training and education of disease process.
2. Physical Therapy Evaluation and Treatment as needed
3. Exercise
   - Per routine protocol (60-85% maximum heart rate)
   - Low level protocol (HR increase of 20-30 beats)
   - Other: _____ Target HR: _____

I certify that:

1. A physical exam has been performed within the last 90 days.
2. The patient is capable and willing to participate in the plan of care.
3. The patient has quit smoking or is willing to participate in smoking cessation activities prior to or during pulmonary rehab services

Physician Signature: _____ Date: _____/ _____/ _____

Phone:_____ Fax:_____