Date: _____

Time in: _____

By: _____

For Office Use Only

PATIENT'S NAME _____ PATIENT'S DATE of BIRTH _____

REFERRING PHYSICIAN _____

PHYSICIAN PHONE NUMBER _____ PHYSICIAN FAX NUMBER _____

For new patients only:

PATIENT'S PHONE NUMBER _____ EMAIL ADDRESS _____

Is it appropriate for the hospital to communicate with you by email? ❑ Yes ❑ No

NAME INSURANCE COMPANY _____ CONTACT NUMBER of INSURANCE COMPANY _____

ID # for INSURANCE COMPANY _____ NAME of INSURED _____

GROUP ID # (Include Insurance Demographics) _____

- ☐ Contact patient to schedule an appointment
- ☐ Patient will contact Cardiopulmonary Rehab to schedule an appointment. Call 972.969.2182
- ☐ Physician's Office has scheduled an appointment for patient. _____ Time _____ Date

PULMONARY REHABILITATION ORDER

Diagnosis for Pulmonary Rehabilitation
Please check those that apply:

- ☐ Emphysema (492.8)
- ☐ Chronic Obstructive Asthma (493.2)
- ☐ Bronchiectasis (494.0)
- ☐ Simple Chronic Bronchitis (491.0)
- ☐ Pulmonary Fibrosis - Post Inflammatroy (515)
- ☐ Pulmonary Fibrosis - Idiopathic (516.3)

☐ Other: _____

☐ Most Recent exacerbation: _____

X _____ _____

Physician Signature *(Stamped Signature not accepted)* Date / Time

LAS COLINAS Medical Center
6800 N. MacArthur Blvd. • Irving, TX 75039
(972) 969-2000
Fax to: 972-969-2519

PATIENT IDENTIFICATION

PULMONARY REHAB ORDER FORM

POS