



# Outpatient Referral

## Pulmonary Rehabilitation Referral

Please provide the information below and fax to: **630.286.4531** or call: **630.286.4540**

<b>PATIENT NAME:</b> <i>(First, M.I., Last)</i>	<b>PATIENT PHONE:</b>
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### PRIMARY DIAGNOSIS

491.0 Simple Chronic Bronchitis	135 Sarcoidosis
491.1 Mucopurulent Chronic Bronchitis	504 Pneumonopathy due to inhalation of other dust
491.20 Obstructive Chronic Bronchitis without exacerbation	505 Pneumoconiosis unspecified
491.8 Other Chronic Bronchitis	506.4 Chronic respiratory conditions due to fumes and vapors
492.8 Other Emphysema	506.9 Unspecified respiratory conditions due to fumes and vapors
493.20 Chronic Obstructive Asthma unspecified	508.1 Chronic and other pulmonary manifestations due to radiation
493.82 Cough Variant Asthma	515 Post inflammatory Pulmonary Fibrosis
494.0 Bronchiectasis without Acute Exacerbation	516.0 Pulmonary Alveolar Proteinosis
494.1 Bronchiectasis with Acute Exacerbation	516.2 Pulmonary Alveolar Microlithiasis
496 Chronic Airway Obstruction Not Elsewhere Classified	516.3 Idiopathic Fibrosing Alveolitis
500 Coal workers' Pneumoconiosis	516.8 Other specified alveolar and Parietoalveolar Pneumonopathies
501 Asbestosis	518.89 Other diseases of lung not elsewhere classified
502 Pneumoconiosis due to other silica or silicates	Other: _____
503 Pneumoconiosis due to other inorganic dust	

### SECONDARY DIAGNOSES (Please list. Examples: CHF, Diabetes, etc.)

### REFERRAL INFORMATION (Please mark the items being faxed.)

<b>H&amp;P</b>	<b>PFT (with Fev1, FVC, DLCO &lt;60%)</b>	<b>Chest X-Ray Report</b>	<b>EKG</b>	<b>Stress Test</b>
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### PHYSICIAN INFORMATION

**PHYSICIAN NAME:**

**THANK YOU FOR YOUR REFERRAL. YOU WILL RECEIVE A REPORT OF THE PATIENT'S PROGRESS.**

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