Pulmonary Rehabilitation Telehealth Patient Referral Form

AMERICAN TELEMEDICINE ASSOCIATION Member

PATIENT INFORMATION

Full Name: _____

Date of Birth: _____

Required: *Attach a face sheet that includes current insurance information.*

MEDICAL INFORMATION

- ☐ COPD/Emphysema
- ☐ COPD/Asthma Overlap
- ☐ Lung Transplant prehab/rehab
- ☐ Endobronchial Valves prehab/rehab
- ☐ Pulmonary Hypertension
- ☐ Interstitial Lung Disease
- ☐ Pulmonary Fibrosis
- ☐ Bronchiectasis
- ☐ Cystic Fibrosis
- ☐ Other

Required: *Attach the most recent office note and PFT (if applicable).*

PROVIDER INFORMATION

Provider Phone: _____ Provider Fax: _____

Practice Contact Name: _____

Practice Contact Email: _____

Provider Print Name: _____

Provider Signature: _____

Date: _____

Fax to: (818)450-0350

QUESTIONS?

Call: (888)450-0377 Email: team@breathebetter.rehab

Contact us to reorder your supply of patient program information brochures!

www.breathebetter.rehab