# Telehealth Pulmonary Rehabilitation Patient Referral Form

**RETURN TO BREATHE BETTER REHAB**
**FAX:** (818) 450-0350
**EMAIL:** TEAM@BREATHEBETTER.REHAB
**OR COMPLETE ONLINE:** WWW.REFERTOPR.COM

HIPAA COMPLIANCE | AMERICAN TELEMEDICINE ASSOCIATION Member

## PATIENT INFORMATION

Full Name: _____ Date Of Birth: _____

Email: _____ Phone: _____

☐ **Required:** Attach the patient's demographic sheet with current insurance information and most recent office note. (Include PFT results, if available).

## MEDICAL INFORMATION

**If Medicare Part B is the patient's PRIMARY insurance, they must have a qualifying diagnosis of COPD (including the subtypes listed below) or Post-COVID-19 Condition (U09.9) to be eligible for our program.***

☐ COPD*
- Emphysema
- Chronic Bronchitis
- Asthma-COPD Overlap
- Chronic Obstructive Asthma

☐ Post COVID-19 Condition*
(Resulting in at least 4 weeks of respiratory dysfunction)

☐ Endobronchial Valves Prehab/Rehab*

☐ Lung Transplant Prehab/Rehab
(Required if selected) Specify Pulmonary Diagnosis: _____

☐ Pulmonary Hypertension

☐ Interstitial Lung Disease

☐ Pulmonary Fibrosis

☐ Bronchiectasis

☐ Other Pulmonary Diagnosis: _____

## PROVIDER INFORMATION

Provider Phone: _____ Provider Fax: _____

Practice Point-of-Contact Name: _____

Practice Point-of-Contact Email: _____

Provider Print Name: _____ Credentials: e.g., MD, DO, NP, PA

Provider Signature: *APP referral requires co-signer _____ Date: _____

☐ *APP Notes Include Electronic Co-Signer OR *Co-Signer Signature: _____

## QUESTIONS?

American Telemedicine Association Member

**Call:** (888) 450-0377 | **Email:** team@breathebetter.rehab | **Fax:** (818) 450-0350
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