CPMC
Sutter Health

SUTTER HEALTH CALIFORNIA PACIFIC MEDICAL CENTER
PULMONARY REHABILITATION SERVICES
PHYSICIAN REFERRAL
QUESTIONS? Please call (415) 600-3471
FAX to:(415) 885-8679

Participant Name: _____
DOB: _____

1. Please check appropriate diagnoses. One must be primary for billing purposes.

Primary	***Secondary***
☐ Emphysema	☐ Diabetes
☐ Chronic bronchitis	☐ Hypertension
☐ Asthma	☐ Heart failure
☐ Restrictive disease – Pulmonary fibrosis, Scleroderma, Sarcoidosis ☐ Other (Please specify _____)	

2. The following medical records are required for entry into the program. If any of the following tests need to be ordered, please do so prior to sending us this referral. Otherwise, please fax all the required documents to (415) 885-8679.

- ☐ Insurance Authorization
- ☐ History and Physical (within the last 90 days)
- ☐ Current progress notes regarding patient's pulmonary health (within 90 days)
- ☐ Pulmonary Function Test (within the last 12 months)
- ☐ EKG/Echocardiogram (within the last 6 months)
- ☐ Chest x-ray/CT

3. Please select an appropriate disease severity rating for this participant:

- ☐ Mild (FEV1 > 80%)
- ☐ Moderate (FEV1 < 80% > 50%)
- ☐ Severe (FEV1 < 50% > 30%)
- ☐ Very Severe (FEV1 < 30%)

4. Please define any special precautions or limitations.

- ☐ Exercise prescription and home management training per CPMC protocol
  or
- ☐ Refer to written instructions below:

_____
_____
_____

_____
MD Signature Printed Name Date