Pulmonary Rehabilitation is designed for persons with chronic lung disease such as emphysema, chronic bronchitis, asthma, bronchiectasis and interstitial lung disease. Pulmonary Rehab provides a level of exercise training and education beyond that which is ordinarily covered by a physician during an office visit.

Admission Criteria:
- Participants entering the program must have physician referral
- Participants must be clinically stable as determined by the referring physician
- Participants must have a physician diagnosis of chronic obstructive, interstitial, occupational or environmental lung disease
- Participants must be non-smokers or participating in a smoking-cessation program

Pulmonary Rehabilitation Helps People with Lung Disease
Pulmonary Rehab offers individuals with lung disease the opportunity to improve their quality of life by restoring them to their fullest functional capacity. This program includes:

- Medical management
- Exercise
- Education
- Breathing retraining
- Emotional support
- Relaxation techniques

Benefits To You & Those You Love
- Reduced number of hospitalizations
- Improved exercise tolerance and level of physical activity
- Improved quality of life
- Potential for return to gainful employment in some participants
- Improved feelings of hope, control and self-esteem
- Improved psychological function with less anxiety and depression
- Family education, involvement and support
- Reduced shortness of breath & respiratory symptoms
Pulmonary Rehabilitation Medical Assessment and Referral Form

to be completed in physician’s office and faxed to the appropriate Pulmonary Rehabilitation Program (above)

Name: ____________________________ Sex: ________ Age: ________ DOB: ________

Mailing Address: __________________ City: ______________ State: ______ ZIP: ______

Phone #: ____________________ Physician: ________________ Physician’s Phone #: ________________

Physician’s Fax #: __________________

Dear Physician:

If you feel that your patient is a candidate and would benefit from Pulmonary Rehabilitation based on the criteria below, please provide diagnosis, ICD-9 code and most recent Pulmonary Function test to initiate placement in the Pulmonary Rehabilitation Program. Please include any pertinent health history, and graded exercise test (GXT).

- PFT to be done prior to admission to program
- Exhibits disabling symptoms, which significantly impairs the patient’s level of functioning
- Expectation of measurable improvement in a reasonable and predictable timeframe
- Be physically able, willing and cooperative in participating in Pulmonary Rehabilitation
- Capable of participating in plan of care
- Non-smoker or will participate in a smoking-cessation program

I certify that the above Pulmonary Rehabilitation treatment is medically necessary and is medically approved by me for treatment of this patient and this patient has had a physical exam in the last 90 days.

I. Medical Conditions:
Diagnosis: ____________________________ ICD-9 Code: ________________

II. Smoking Cessation Program:
Refer to FirstHealth Tobacco Cessation Program:  □ Yes  □ No

Physician’s Signature: __________________ Date: ________________

TO THE PATIENT REFERRED TO THE PULMONARY REHABILITATION PROGRAM:

The cost of the Rehabilitation Program may be covered by medical insurance. However, this coverage varies widely from company to company. In addition, the company will cover a limited number of exercise sessions. If, for some reason, Medicare or any other insurance carrier should deny payment on your claim, you are financially responsible for any services rendered by FirstHealth of the Carolinas. Also, if you should extend your program beyond the number of sessions designated by your insurance carrier, you will be financially responsible for all services rendered from that date forward. I have read and understand the above information.

Patient’s Signature: __________________ Date: ________________