NYU Langone MEDICAL CENTER

ACC - RUSK INSTITUTE OF REHABILITATION MEDICINE
The Joan and Joel Smilow Cardiac Rehabilitation Center
240 East 38th Street • 16th Floor • New York, NY 10016
Telephone: (646) 501-7733/7734 • www.med.nyu.edu/cardiacrehab

Outpatient Pulmonary Rehabilitation Referral Form

FAX to the ACC RUSK INTAKE / REGISTRATION at (646) 754-9652

Date: _____

Patient Name: (Last)_____(First)_____

Date of Birth:_____ Gender (Please Circle): F M Social Security:_____

Patient Address: _____

Patient Phone: (H)_____(W)_____(C)_____

Primary Insurance:_____

Policy ID#:_____Insured Name:_____

Secondary Insurance:_____

Policy ID#:_____Insured Name:_____

Medical Diagnosis: _____ ***ICD 9:*** _____

_____Asthma 493.0
_____Aspiration Pneumonia 507.0
_____Bronchiectasis (w/o acute exacerbation) 494.0
_____Bronchiectasis (w/ acute exacerbation) 494.1
_____Bronchitis 491.2
_____COPD 496
_____Other _____

_____COPD (w/acute respiratory distress) 496 & 518.82
_____Cystic Fibrosis 277.0
_____Dyspnea 786.09
_____Emphysema 492.8
_____Mucopurulent Chronic Bronchitis 491.1
_____Pneumonia 486
_____Shortness of Breath 786.05

Risk Factors: (please select ALL that apply)

_____Hypertension _____Hyperlipidemia _____Diabetes _____Obesity
_____Smoking _____Sedentary Lifestyle _____Post Menopausal _____Family History

Significant Medical/Orthopedic Problems (Please Circle): Yes No

Description: _____
_____

Physician Order: Pulmonary Rehab ____ V02 Stress Test ___

Frequency and Duration: _____ _____
(times/week) (45 minutes per session)

PLEASE ATTACH A COPY OF RECENT CT SCAN OR CXE REPORT IF AVAILABLE

Physician's Name/Specialty (Please Print) _____

NPI#: _____ License Number:_____ UPIN:_____

Physician's address:_____

Office Telephone: (_____)_____ Office Fax: (_____)_____

Physician's Signature: _____