NYU Langone MEDICAL CENTER

ACC - RUSK INSTITUTE OF REHABILITATION MEDICINE
240 East 38th Street • 16th Floor • New York, NY 10016
Telephone: (212) 263-6033 • Website: www.ruskinstitute.org

Outpatient Chest Physical Therapy Referral Form

FAX to the ACC RUSK INTAKE / REGISTRATION at (212) 263-0113

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 code:_____

_____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
____Pneumonia 486
____Mucopurulent Chronic Bronchitis (491.1)

Please Indicate:

Patient ***does/does*** not have Cardiac Disease/GERD
(please circle)

Patient ***may/may not*** be placed in the Trendelenberg position
(please circle)

Prescription for: (please select)

_____Postural Drainage: (Including self treatment techniques)

_____RUL _____RML _____RLL _____LUL _____LUL (Lingula) _____LLL

_____ACAPELLA instruction _____LUNG FLUTE Instruction

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

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

Physician's Name/Specialty (Please Print) _____
NPI#: _____ License Number:_____ UPIN:_____
Physician's address:_____
Office Telephone: (_____)_____ Office Fax: (_____)_____
Physician's Signature: _____