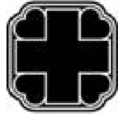

Beaufort Memorial HOSPITAL

Out Patient Pulmonary Rehab Physician Order

Patient Information	**Pt Acct #:**	
Patient Name (Last, First, MI)		
Address:		
DOB	**Sex** ☐ **M** ☐ **F**	**Patient SS#**

Referral For: ☐ Pulmonary Rehab

Diagnosis: ☐ COPD (496) ☐ Asbestosis (501) ☐ Bronchitis with acute exacerbation (494.1)

☐ Sarcoidosis (135) ☐ Chronic Bronchitis (491) ☐ Pulmonary Fibrosis (515) ☐ Asthma (493)

☐ Lung Transplant (V42.6) ☐ Emphysema (492) ☐ Chronic Respiratory Failure (518.83)

☐ Other

Medical History: ____

____

Has this patient had:	**YES**	**NO**
History & Physical	☐	☐
Recent Office Visit	☐	☐
EKG	☐	☐
Surgery Reports	☐	☐
****Lipid Profile**	☐	☐
Blood Sugar (Glucose)	☐	☐
PFT	☐	☐

`

NOTE: Please send copies of these reports if available.

****Lipid profile of six or more weeks. If not available, I authorize that necessary labs be obtained at Beaufort Memorial Hospital.** **YES** ☐ **NO**☐

SPECIAL INSTRUCTIONS: ____

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Physician's Signature: ____________________________ **Date/ Time:** ____________________________