

Memorial Hermann Texas Medical Center Pulmonary Rehabilitation Referral Orders

TMC Wellness Center 6414 Fannin St G-100, Houston, Texas 77030 Phone: 713-704-5805
Physician Order and Referral Form Fax referral to 713-704-6358
cardiacandpulmonaryrehabTMC@memorialhermann.org

Date of Referral: _____

Patient Name: _____ Date of Birth: _____

Patient Cell Phone: _____ Alternate Phone: _____

Physician Name: _____

Physician Address: _____

Physician's Phone Number: _____ Fax Number: _____

CLINICAL INFORMATION

Does your patient require an interpreter? YES NO If YES, preferred language: _____

Additional clinical information/special needs: _____

Please evaluate and treat the above patient for respiratory dysfunction secondary to:

Check	ICD 10 Codes	Diagnosis	Check	ICD 10 Codes	Diagnosis
<input type="checkbox"/>		Asthma	<input type="checkbox"/>		Interstitial Lung Disease
<input type="checkbox"/>		Bronchiectasis	<input type="checkbox"/>		Lung Transplant (Pre - Post)
<input type="checkbox"/>		COPD	<input type="checkbox"/>		Obstructive Sleep Apnea
<input type="checkbox"/>		Cystic fibrosis	<input type="checkbox"/>		Pulmonary Fibrosis
<input type="checkbox"/>		Post Covid-19 Syndrome	<input type="checkbox"/>		Pulmonary Hypertension
<input type="checkbox"/>		Other:	<input type="checkbox"/>		Sarcoidosis
<input type="checkbox"/>			<input type="checkbox"/>		

Pulmonary Rehabilitation CPT 94625, 94626 - Outpatient Respiratory Services CPT G0239, G0238, G0237

PULMONARY REHAB SCHEDULE: Tuesday – Thursday and /or Saturday 12 weeks / 36 sessions

The following order set is included in the prescription for pulmonary rehabilitation:

- | | |
|------------------------------------|--|
| 6MWT | Non-Invasive ventilation |
| Oxygen therapy with rehabilitation | Chronic Lung Disease Patient Education |
| Spirometry | Occupational Therapy |
| Volume Expansion | Dietary Evaluation |
| Secretion Clearance | Glucose Monitoring |

Outpatient Pulmonary Rehabilitation at Memorial Hermann in the Texas Medical Center is performed under the Supervision of Board Certified Pulmonary and Critical Care Physicians

I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

AM
 PM

Provider Signature Print Name NPI/MHHS ID. Date Time Contact No.



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Referral Orders**

