Duke Raleigh Hospital
DUKE UNIVERSITY HEALTH SYSTEM

Pulmonary Rehabilitation & Wellness Center Physician Referral

3301 Executive Dr.
Raleigh, NC 27609
Office: 919-954-3174 Fax: 954-3177

Date:________________
Patient Name (please print):____ DOB:______________________
Patient Phone Number: _______________________________

Outpatient Pulmonary Rehabilitation:

❑ Outpatient Pulmonary Rehab – Must indicate diagnosis code from list below:

Standing Order Evaluation Studies:

Baseline diagnostic studies assist in proper diagnosis of the rehabilitation candidate and the development of an appropriate plan of care. The following diagnostic tests will be completed prior to admission into Pulmonary Rehabilitation:

- Cardiac Stress Test
- Full Pulmonary Function Tests to include: spirometry, lung volumes, and diffusion capacities
- EKG
- 6 min walk test at entry and upon conclusion of cardiac rehabilitation program
- RT evaluation

Diagnosis Code:

❑ 496 - COPD
❑ 494.0 - Bronchiectasis
❑ 416 – Pulmonary Hypertension
❑ Other ________________________
❑ 135 - Sarcoidosis
❑ 501 - Asbestosis
❑ 491 – Chronic Bronchitis
❑ 493.20 – Chronic Obstructive Asthma
❑ 516.3 – Interstitial Pulmonary Fibrosis
❑ Other ________________________

*Along with this order, please send the following: copy of physical and history, CXR, hospital discharge summary if recently admitted.

Other Wellness Center Programs:

❑ Pulmonary Maintenance
❑ Better Balance – 12 week program
❑ Cancer Wellness Program – 12 week program
❑ Weight Loss Program (Lose To Live)
❑ Diet and Nutrition Counseling
❑ Adult Fitness Program
❑ Cardiac Rehab – Call 954-3174 for referral form
❑ Cardiac Maintenance
❑ Weight Loss Surgery Wellness

* Members will be considered for Adult Fitness Program structured to individual needs.

Diagnosis Code:

❑ 414.01 – Coronary Artery Disease
❑ 428.0 – Congestive Heart Failure
❑ 274.4 – Hyperlipidemia
❑ 250.0 - Diabetes
❑ V45.01 – Cardiac Pacemaker
❑ 401.9 – Hypertension
❑ 278.0 – Obesity
❑ 43770 s/p Lap Band procedure
❑ 443.9 - PAD
❑ 272.0 – Hypercholesterolemia
❑ 278.01 – Morbid Obesity
❑ 43846 – s/p Gastric Bypass

Other: ________________________

Precautions/Limitations:

❑ Non-weight bearing exercise ❑ Heart Rate Range - _______________ ❑ Other: ______________________

I certify that the above treatment is medically necessary and is medically approved by me for the treatment of this patient.

Physician's Signature:____ Phone Number: _______________
Physician Name (Please Print):__________________________________ Fax Number: ________________

Thank you for this referral.