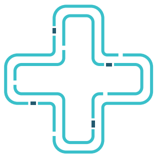

CULLMAN REGIONAL

**Cullman Regional Therapy Services**
1948 Alabama Highway 157
POB I, Ground Floor
Cullman, AL 35058
**Phone:** 256-737-2271

# CARDIOPULMONARY REHAB PATIENT REFERRAL FORM

## ORDERING PROVIDER

Date ________________ Outpatient: Phase II Monitored _______ Outpatient: Phase III Unmonitored _______

Referring MD ____________________________________________

Phone # ______________________ Fax # ______________________

Address ______________________ City __________ State __________ Zip __________

Patient's Name ______________________ Age ________ DOB ______________________

Phone # ______________________ Cell # ______________________

Health Insurance #1 ______________________ Policy # ______________________

Health Insurance #2 ______________________ Policy # ______________________

## CARDIAC REHABILITATION

M.I. ____________ CABG ____________ Stable Angina ____________ PTCA Coronary Stent ____________

Heart Valve Replacement/Repair ____________ CHF ____________ Other ______________________

## PULMONARY REHABILITATION

Chronic Bronchitis ______________ COPD ______________ Emphysema ______________

Asthmatic Bronchitis ______________ Asthma ______________ Cystic Fibrosis ______________

Pulmonary Fibrosis ______________ Lung Surgery ______________ Other ______________

**Please include the following with the signed referral:**

1. Recent D/C summary or clinical note that describes recent event, cardiac/pulmonary
2. Current Medications
3. Resting EKG
4. PFT's for Pulmonary Rehabilitation

*Special Instructions* ____________________________________________

____________________________________________

____________________________________________

**Physician Signature** ______________________ **Date/Time** ______________________

Phone 256-737-2271 • Fax 256-737-2560