Onslow Medical Specialties Clinic –Lung & Sleep Disorders Clinic
Pulmonary Rehabilitation Program
Eusebio Desuyo, MD, MBA, MPH
123 Pompano Place, Suite 100
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Phone 910-455-9398
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Pulmonary Rehabilitation Request/ Referral

Patient: _____SS# _____
DOB: _____ Height: _____(feet/inches)Weight :_____(lbs)
Address: _____City/State_____ Zip:_____
Home Phone:_____ Work/ Cellphone:_____
We will need fax copies of patient's health insurance card (front & back), Driver's License/State ID, and History & Physical Notes/Progress Notes/ Medications list.

Referring Physician: _____NPI#:_____
Referring Physician's Address:_____
_____
Phone & Fax _____

Reasons for Pulmonary Rehabilitation Referral: (please check reasons that apply)

__ Severe COPD (FEV-1 < 50% and > 30% predicted; FEV1/FVC less than 70% predicted).
___Very Severe COPD (FEV-1 < 30 % predicted; FEV1/FVC less than 70 % predicted).
___ Moderate COPD (FEV-1 < 80% predicted and > 50 % predicted; FEV-1/ FVC ratio less than 70%) and symptomatic.
___ Others: _____

_____

I authorize Onslow Medical Specialties Clinic – Lung Clinic /Pulmonary Rehabilitation Center to evaluate above patient for possible pulmonary rehabilitation, as a medical necessity.

Referring Physician Signature:_____ **Date**:_____