FlexTogether
A Respiratory Rehab Clinic

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Referral for FlexTogether Virtual Pulmonary Rehab

Please Fax to 888-505-1941

- ☐ **1. This signed referral form**
- ☐ **2. Most recent office note with medications**

Patient's Name:_____ **Date of Birth:**_____/_____/_____

Patient's Telephone Number:_____

Diagnosis:

- ☐ **ICD-10 code J44.9: Chronic Obstructive Pulmonary Disease, Unspecified**
- ☐ **ICD-10 Code J84.9: Interstitial Pulmonary Disease, Unspecified**
- ☐ **ICD-10 Code U09.9: Post COVID-19 Condition, Unspecified**
- ☐ **Other Diseases** _____

PROVIDER'S ORDERS

- **Physical Therapy: Evaluation and Therapy**
- **Speech Therapy: Evaluation and Therapy**

SIGNATURE REQUIRED FOR REFERRAL

Printed Name of Physician/PA/NP _____

Physician's/PA's/NP's Signature_____**Date**_____

By signing, I acknowledge that this patient does not have any absolute contraindications listed below.

Absolute Contraindications
• Unstable heart condition: unstable angina, arrhythmia, or uncontrolled heart failure, recent acute coronary syndrome. • Unstable bone fracture • Pulmonary hypertension defined by a pulmonary artery pressure greater than 25 mmhg or on any pulmonary hypertension treatments • Severe cognitive impairment that would interfere with participation • Uncontrolled psychiatric disease • Impaired eyesight or hearing that would make participation challenging • Severe uncontrolled anemia

Other Comments: