TRULY
Effective Respiratory Care

Office: (407) 900-1249 **Fax: (321) 999-9239** **Office@TrulyResp.com**

Respiratory Therapy Manual Chest Physiotherapy (CPT) Referral Form

Today's Date: _____

PATIENT INFORMATION

Last Name:	First:	Date of Birth:
Address:		
Home Phone:	Cell Phone:	

FEV1: _____ Approximate Date: _____	Last Hospital Admission Date: _____	PLEASE INCLUDE LAST OFFICE VISIT NOTES Last Office Visit Date: _____
CULTURE RESULTS (CF Only): ❑ Microorganisms ❑ Normal flora	***CHECK FOR EACH (CF Only):*** ❑ Burkholderia species ❑ Mycobacterial species ❑ Klebsiella species ❑ Fungal/Yeast	❑ Staphylococcus aureus: MRSA, MSSA ❑ Pseudomonas aeruginosa ❑ Haemophilius influenzae ❑ Enterobacter species ❑ Other _____

PLEASE INCLUDE PATIENT DEMOGRAPHIC SHEET AND CLINICAL NOTES

ORDERS

❑ Manual/Hand Chest Percussion Therapy (CPT) to clear lung secretions with evaluation/assessment and respiratory treatment adherence education. (G0238) (G0237) (99503)

❑ _____ Times per day

❑ _____ Times per week

FOCUS AREA/PROBLEM AREA FOR TREATMENT

LEFT LUNG	***RIGHT LUNG***
❑ Upper Lobe	❑ Upper Lobe
❑ Lower Lobe	❑ Middle Lobe
	❑ Lower Lobe

DIAGNOSIS AND CODE

	ICD-10 CODE	***DESCRIPTION***
❑	E84.9	Cystic fibrosis, unspecified
❑	J47.9	Bronchiectasis
❑	J22	Unspecified acute lower respiratory infection
❑	J98.4	Other disorders of lung
❑	Other:	_____

ORDERING PHYSICIAN INFORMATION

Ordering Physician (please print):	Date:
Signature	
Tax ID#	NPI