**OKEENE MUNICIPAL HOSPITAL**

**Pulmonary Rehabilitation & Diagnostic Center**

**207 East F Street**

**Okeene, Oklahoma 73763**

* **Phone: (580) 822-4400**
* **FAX: (580) 822-3018**

**PATIENT REFERRAL FORM**

* + Please enroll the above referenced patient in the Respiratory Care & Pulmonary Rehabilitation Program.
  + I understand that certain diagnostic tests may be required prior to enrollment of my patient, if not provided **(*i.e. Pulmonary Function Tests, Pulmonary Stress Test / 6 Minute Walk Test, & Electrocardiogram)*.**
  + Attached are the most recent physician office visit notes, diagnostic tests and patient insurance information for your use ***(include copy of front and back of the patient’s insurance card if available***).

Referring Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**PLEASE FAX TO (580) 822-3018 (10/2023)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_\_/\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_**

**Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ICD10 Diagnosis Code(s): \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_**