CORDELL MEMORIAL HOSPITAL

Pulmonary Rehabilitation & Diagnostic Center
1220 North Glenn L English Street
Cordell, OK 73632

- **Phone: (580) 832-3339 Ext 109**
- **FAX: (580) 832-5076**

PATIENT REFERRAL FORM

Name: ______________________________ **DOB:** ___/____/____

Address: ____

City: _____________________ **State:** ____ **ZIP CODE:** ________

Phone: (_____) ____

ICD10 Diagnosis Code(s): ________/_______/________/______

- 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) 832-5076 **(10/2023)**