Pulmonary Referral Form

Patient Information

Full Name: _____.

Date of Birth ____ /_____/_____.

Phone Number: _____.

Address: _____.

City/ State/ Zip: _____.

Email: _____.

Referring Pulmonologist Information

Name NPI: _____.

Practice /Clinic Name; _____

Phone: _____.

Fax: _____.

Address: _____.

Reason for RPM Referral (Check all that apply)

- ☐ COPD
- ☐ Asthma
- ☐ Pulmonary Fibrosis
- ☐ Sleep Apnea
- ☐ Chronic Bronchitis
- ☐ Post- Covid Monitoring
- ☐ Other: _____

Monitoring Needs (Check all that apply)

- ☐ Continuous Pulse Oximetry
- ☐ Peak Flow
- ☐ Blood Pressure Monitoring
- ☐ Weight Monitoring (CHF - related pulmonary care)

Clinic Goals for RPM

- ☐ Reduced ER visits & hospitalizations
- ☐ Early detection of exacerbations
- ☐ Medication adherence monitoring
- ☐ Support pulmonary rehabilitation program
- ☐ Other:_____

COMMUNITY STRONG LLC
307-877-2951
877-552-0705
www.communitystrongwy.com
cs@communitystrongwy.com

Duration of Time: 0-99 months_____.

Monitor how many times a day: _____.

Other (write-in ICD-10 or clinical reason): _____

_____.

HIPAA Compliance & Authorization to Bill

I acknowledge that I have been informed of my rights under the Health Insurance Portability and Accountability Act (HIPAA). I consent to the secure collection, transmission, and use of my health information for medical monitoring, treatment, and billing purposes.

I authorize Community Strong LLC and its billing partners to submit claims to my health insurance for Remote Patient Monitoring (RPM) services rendered and to receive direct payment for these services. I understand that my insurance may be billed monthly for monitoring services and I may be contacted by a health coach or clinician.

Patient Consent:

Verbal Consent Given (initial by provider: _____
Patient Signature: _____ Date: ____ / ____ / _____
Provider Signature: _____Date: ____ / ____ / _____