



## Questions from the RITTS – Respiratory Rehabilitation Referral

Please note that shaded boxes are mandatory.

Patient name	Date
Type of rehabilitation service	Sending physician
Receiving facility	Receiving physician

What is the primary diagnosis?  <input type="checkbox"/> Bronchitis <input type="checkbox"/> COPD <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Pre/post lung transplant <input type="checkbox"/> Pulmonary Fibrosis <input type="checkbox"/> Other ☞	If you selected "Other", please specify:				
What is the secondary diagnosis?  <input type="checkbox"/> COPD <input type="checkbox"/> OA <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis <input type="checkbox"/> RA <input type="checkbox"/> Sleep Disordered Breathing <input type="checkbox"/> Other ☞	If you selected "Other", please specify:				
What is the major reason for the referral?  <input type="checkbox"/> Decreased level of activity <input type="checkbox"/> Equipment needs <input type="checkbox"/> Increased shortness of breath <input type="checkbox"/> Lung Hygiene <input type="checkbox"/> Medication education <input type="checkbox"/> Oxygen use					
Does the patient smoke?  <input type="checkbox"/> Yes <input type="checkbox"/> No					
If the individual has any of the following infectious organisms, please specify:		If you selected 'Other,' please specify:			
<input type="checkbox"/> C-dif <input type="checkbox"/> MRSA <input type="checkbox"/> TB	<input type="checkbox"/> VRE <input type="checkbox"/> Other ☞ <input type="checkbox"/> None				
Please input the results for the following tests / investigations:		Completed	In Progress	N / A	
		CAT Scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Echocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Other ☞	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		If you selected "Other," please specify:			



# Rehabilitation Integrated Transition Tracking System (RITTS)

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Please list medications:

Are there any allergies?

- Yes ☞
- No

If you selected 'Yes,' please specify:

Other information and/or investigations and tests to follow via fax or mail.  
(A facility's contact information can be found using the Find a Rehab Service tab.)

**Please forward all pertinent investigative reports and consult notes.**