

CHRONIC OBSTRUCTIVE PULMONARY DISEASE PHYSICIAN QUERY FORM

THIS FORM IS A PERMANENT PART OF THE MEDICAL RECORD

Date: _____

Dear Dr. _____:

**Please return this form by fax to:
XXX-XXX-XXXX**

In responding to this query, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular answer is desired or expected. Thank you for your clarification on this documentation.

Coder's Name: _____ Coder's Phone #: _____

Patient Name: _____

Admit Date: _____ Discharge Date: _____

MR#: _____ Acct #: _____

The physician must have documented Chronic Obstructive Pulmonary Disease (COPD) and the patient must have significant clinical indicators for the type and/or time scale of COPD present prior to querying. Significant clinical indicators are defined as having or likely to have influence or effect or probably caused by something other than mere chance.

The medical record reflects the following clinical findings suggestive of COPD:

Check here if indicator is present	Clinical indicator	Location in the medical record which reflects the clinical findings
	Increased wheezing	
	Clear, Yellow or Green mucus/sputum with cough	
	Use of accessory muscles	
	Increased allergy or hay fever symptoms	
	Increased irritation or swelling of mucous lining of airways	
	Exposure to smoke, chemicals or air pollution	
	Abnormal pulmonary function test or chest x-ray	
	Airflow obstruction	
	Chest pain or tightness	
	Skin Rash	

Please respond to the following question and take the appropriate action based on your response:

Based on your medical judgment of the clinical indicators outlined above, can you identify the specific type (e.g. extrinsic asthma, intrinsic asthma, bronchitis, bronchiectasis, emphysema, etc.) and acuity of the COPD (e.g. acute, chronic, acute exacerbation of chronic, etc.)?

If yes, please document the specific type and acuity of COPD in the space below and/or in the medical record (progress notes, dictated report, or as an addendum to a dictated report), sign and date.

If no, please initial in or check the box, sign and date.

If unable to determine, please initial in or check the box, sign and date.

PHYSICIAN SIGNATURE

DATE