

CARDIAC REHABILITATION REFERRAL

Phone: 973-429-6199 Fax: 973-680-7741

Date: _____

Patient Name: _____

Address: _____

Phone: _____

Diagnosis/Date: _____

CABG - V45.81 MI - 410.____ STABLE ANGINA - 413.9 HEART TRANSPLANT - V42.1

VALVE REPLACEMENT - V43.3 PTCA/STENT - V45.82 Other _____

PRESCRIBED TREATMENT

PHASE II - MONITORED

LENGTH OF STAY IN PROGRAM

FAST TRACK = 4-6 weeks _____ DX: Uncomplicated MI, PTCA, Stent

CRITERIA: EF greater than 50%, No Complex Dysrhythmias, No CHF or Angina

SLOW TRACK = 12 weeks _____

INTENSITY

From recent stress test, 70-85% of the MHR = THR range of _____

No recent stress test, 30-50% ↑ avg RHR = THR range of _____

Patient's rating of perceived exertion (RPE) = 12-15 BORG scale

Other

DURATION: Progress exercise 20-40 minutes per protocol

FREQUENCY: Schedule exercise sessions 3 X per week

PHASE III/PHASE IV - NON-MONITORED

NUTRITIONAL CONSULTATION: _____

SEND COPIES OF:

STRESS TEST REPORT WITH EKG
CBC, LYTES, LIPIDS
MEDICATIONS

All treatment programs are designed to facilitate maximum function. This prescription serves as a statement of medical necessity for the above mentioned patient.

Physician Signature: _____ Office Phone Number: _____

Physician Name (Please Print): _____