



**Maine Coast Memorial Hospital
Cardiac Rehabilitation**
50 Union St.—Ellsworth, ME 04605
207-664-5434

MCMH Cardiac Rehabilitation Referral Form

Name: _____ D.O.B.: _____ Date: _____
Diagnosis: _____ Phone: _____
Allergies: _____ Physician: _____

Risk Factors (please circle):

Smoker: Y N Amount _____ Diabetes: NIDDM IDDM
Hypertension: Y N Obesity: Y N
Sedentary Life Style: Y N Stress: Y N
Hypercholesterolemia: Y N Family History: Y N

Most recent lipid panel

Date: _____ Total Cholesterol: _____ HDL: _____ LDL: _____ Triglycerides: _____

Most recent stress test: Date _____ (please attach information if available)

Brief Summary of Cardiac History:

Current Medications (print below or attach separate updated list):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list **special instructions** or any **medical conditions** that may affect patient in CRII:

Referral for MCMH Phase II Cardiac Rehab: Y N

Physician's Signature: _____ Date: _____

Physician: If you approve, please sign and date this referral form and fax it back to MCMH Cardiac Rehabilitation Department (207) 664-5453. Thank-you! MCMH Cardiac Rehab Team