



CARDIAC REHABILITATION

PHONE- 664-5636 FAX- 664-5453

Patient Name: _____	Sex: <u>M - F</u>	D.O.B. _____
Address: _____	(city) _____	(state) _____ (zip) _____
Phone : (home) _____	(work) _____	(cell) _____ SS# _____
Insurance: _____	Policy# _____	Group# _____ Auth # _____

If patient is not in MCMH information system please send H& P and last office note.

DIAGNOSIS

<input type="checkbox"/> Heart attack within the last 12 months (412)	<input type="checkbox"/> Coronary by pass surgery (V45.81)
<input type="checkbox"/> Stable Angina pectoris (413.9)	<input type="checkbox"/> Heart valve repair/replacement (V45.82)
<input type="checkbox"/> Angioplasty or coronary stenting (V45.82)	<input type="checkbox"/> Heart of Lung transplant (V42.1/V42.6)
<input type="checkbox"/> Other _____	

MODIFIABLE/CONTROLLABLE RISK FACTORS

<input type="checkbox"/> Smoking	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Body Weight	<input type="checkbox"/> High Stress Levels	<input type="checkbox"/> Sedentary Lifestyle
<input type="checkbox"/> High blood cholesterol and triglycerides		

- Frequency:** **Monitored exercise** 3 times/week or other frequency (must specify) _____
- Duration:** 12 weeks or other duration (must specify) _____
- ETT or EKG:** (or results performed within the last 3 months) _____
- A physical exam has been performed and the patient is physically capable of participating. Patient is willing to cooperate and participate in Cardiac Rehabilitation.*

PHYSICIAN Signature: _____ **Referral Date:** _____