Cardiopulmonary Rehabilitation

REFERRAL FORM

Cardiac Rehab Services

Name: _____ Date of Birth: _____

Referring Physician: _____, M.D.

Patient Phone Number: _____

Date of Current Onset of Illness: _____

Diagonsis(es) - check all that apply

_____ Coronary Artery Disease
_____ Stable Angina
_____ Post Myocardial Infarction
_____ Post Operative Cardiovascular
_____ Post Angioplasty
_____ Cardiac Dysrhythm
_____ Congestive Heart Failure
_____ Peripheral Arterial Disease
_____ Pulmonary Disease
Other: _____

TREATMENT PLAN

Exercise Frequency:
_____ 3 times per week
_____ other: _____
ECG Monitoring:
_____ 6 ECG's per visit
_____ other: _____
Program Duration:
_____ 36 visits with ECG
_____ Maintenance Program
Behavior Modification
_____ YES _____ NO

Comments: _____

_____

PLEASE ATTACH THE FOLLOWING DOCUMENTATION (IF AVAILABLE)

History and Physical (most recent)
Operative Reports
Stress Test Results
Any Consults
Echocardiogram Results
PATIENT DEMOGRAPHICS
Discharge Summary
12 Lead ECG

_____, M.D. Date: _____
Signature of Referring Physician

PLEASE EMAIL OR FAX SUPPORTING DOCUMENTATION TO INITIATE SERVICES
Fax: 504-861-9704 Phone: 504-861-9981