



First Avenue at 16th Street; Linsky Building 3rd Floor
Phone: (212) 420 – 2357 Fax: (212) 844 - 1446

REFERRAL FOR CARDIAC REHABILITATION

Please complete form in as much detail as possible and fax to above number. Thank you for your referral.

Patient Name: _____ Referring MD: _____

Date of Birth: _____ MD address: _____

Pt. Address: _____

Pt. Phone #: _____ MD phone #: _____

MD fax #: _____

MD email address _____

Indications: _____

Past Medical History: (please check all that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> CAD | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> PTCA/PCI | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Angina | <input type="checkbox"/> H/O V-Tach | <input type="checkbox"/> PPM/AICD | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Acute MI | <input type="checkbox"/> CHF | <input type="checkbox"/> Valve Surgery | |
| <input type="checkbox"/> Old MI | <input type="checkbox"/> H/O AFIB | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Valve Disease | <input type="checkbox"/> CABG | <input type="checkbox"/> COPD | |

Does the patient have an **Advance Directive** on file? YES NO

Please attach results of recent **EKG, Stress Test, Lipid Profile, and Cardiac Catheterization report.**

An **Exercise Stress Test MUST** be performed prior to initiating cardiac rehab. Please check the box if you want the test to be completed at the center. **YES, please perform this test at the cardiac rehab center.**

Additional information or instructions:

I have examined the above patient and have found him/her to be free of active infectious disease. Chest x-ray and lab data are all acceptable and the patient is cleared for PT evaluation and treatment for Cardiac Rehabilitation at the Center for Cardiac and Pulmonary Health.

MD Signature: _____ Date: _____