1 Bay Ave Montclair, NJ 07042

CARDIAC REHABILITATION REFERRAL

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

Dr.____________________

Date: ______________

PATIENT NAME: ____DOB____________

ADDRESS: ____

PHONE: ____

DIAGNOSIS/DATE: ____

☐CABG – Z95.1 ☐STABLE ANGINA – I20.9 ☐HEART TRANSPLANT – Z94.1 ☐VALVE REPLACEMENT – Z95.2

☐VALVE REPLACEMENT – Z95.2 ☐ ≤ 4 wks post MI – I21.___ ☐ ≥ 4 wks post MI – I25.2 ☐PTCA/STENT – Z95.5

☐PTCA- Z98.61 Other____________________

☐ Stable Chronic HF – I50.22 or___________

For CHF all criteria must be met: EF ≤ 35%___________ (**send documentation**) NYHA class II-IV_______

Optimal medical therapy x 6wks _____ No planned cardiovascular procedures for at least the next 6 months____

PRESCRIBED TREATMENT

PHASE II – MONITORED

LENGTH OF STAY IN PROGRAM

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

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

____ SLOW TRACK = 12 weeks

INTENSITY

____ From recent stress test, 70-85% of the Max HR = THR range

____ No recent stress test, resting HR +20-40bpm = THR range

____ Patient's rating of perceived exertion (RPE) = 11-14 BORG scale

DURATION: Progress exercise 20-40 minutes per protocol

FREQUENCY: Schedule exercise sessions 3 X per week

NUTRITIONAL CONSULTATION: _________

PLEASE SEND COPIES OF: EKG, CBC, LYTES, LIPIDS, MEDICATION LIST, STRESS TEST (if necessary)

____I authorize cardiac rehab to order the tests indicated below that were not performed in the last 6 months:

___EKG, ___CBC, ___LYTES, ___LIPIDS

PHASE III/PHASE IV - _____ NON-MONITORED (intermittent rhythm strips & BP's)

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:________________________________ Phone #____________________

PHYSICAN NAME (PLEASE PRINT):____