

Cardiac Rehabilitation Phase II Program Exercise Referral Form

PARTICIPANT NAME: _____ DATE: _____

PARTICIPANT PHONE NUMBER: (H) _____ (W) _____

PHYSICIAN: _____ PHYSICIAN'S PHONE #: _____

 REFERRAL TO: PHASE II (Telemetry-monitored exercise sessions **CPT code: 93798**) for 36 sessions
 TO BE COMPLETED BY PHYSICIAN: **PLEASE FILL OUT NUMBERS 1-5 COMPLETELY**
Fax to: 443-643-3731

1. **Please check the appropriate diagnosis. Please indicate all that apply. ICD-9 Code and Specific Date (00/00/0000) Must be included with diagnosis**

<i>Primary:</i>	ICD-9 Code	Date
<input type="checkbox"/> MI	410.90	_____
<input type="checkbox"/> CABG	V45.81 (and 414.00)	_____
<input type="checkbox"/> Stable angina	413.9	_____
<input type="checkbox"/> PTCA/stent	V45.82 (and 414.00)	_____
<input type="checkbox"/> Valve repair/replacement	V43.3	_____
<input type="checkbox"/> Heart transplant	V42.1	_____
<input type="checkbox"/> <i>Specify Other:</i>	ICD-9 Code	Date
<i>(ex, Cardiomyopathy, CHF, etc)</i>	_____	_____
_____	_____	_____
_____	_____	_____

2. **Non-cardiac history:** _____

3. **Exercise Prescription:** (Boxes MUST be checked)

 Per protocol Special recommendations: _____

4. **Education:** (Boxes MUST be checked)

 Per protocol Special recommendations: _____

5. **Counseling, behavior changes, Psychosocial intervention** (Boxes MUST be checked)

 Per protocol Special recommendations: _____

Physician Signature _____

Date _____

PLEASE SEND THE FOLLOWING MEDICAL INFORMATION:

- | | |
|--|---|
| <input checked="" type="checkbox"/> Current medications | <input checked="" type="checkbox"/> Graded exercise test with medication list, if available |
| <input checked="" type="checkbox"/> Exercise referral form and <i>SIGNED</i> | <input checked="" type="checkbox"/> Surgical report, if appropriate |
| <input checked="" type="checkbox"/> Physician Order Form | <input checked="" type="checkbox"/> Ejection Fraction |
| <input checked="" type="checkbox"/> Most recent cholesterol values | <input checked="" type="checkbox"/> Most recent catheterization report, if appropriate |
| <input checked="" type="checkbox"/> Other labs as appropriate | <input checked="" type="checkbox"/> Pacemaker/AICD settings, if appropriate |
| <input checked="" type="checkbox"/> History/physical or discharge summary (reflecting most recent event) | <input checked="" type="checkbox"/> Any other relevant medical information |
| <input checked="" type="checkbox"/> Recent 12 lead EKG | |