

**Patient Information:**

**Date:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
 (City) (State) (Zip Code)

Phone: \_\_\_\_\_

Patient SS#: \_\_\_\_\_ Sex: M F

**Diagnosis:**

<b>Post MI – within last year</b> <input type="checkbox"/> - 121.01 STEMI L main coronary artery <input type="checkbox"/> - 121.02 artery L anterior descending coronary artery <input type="checkbox"/> - 121.09 other coronary artery – anterior wall <input type="checkbox"/> - 121.11 R coronary artery <input type="checkbox"/> - 121.19 other coronary artery – inferior wall <input type="checkbox"/> - 121.21 L circumflex coronary artery <input type="checkbox"/> - 121.29 other sites <input type="checkbox"/> - 121.3 unspecified sites		<b>Post CABG</b> <input type="checkbox"/> - 125.5 Ischemic cardiomyopathy <input type="checkbox"/> - 125.811 Atherosclerosis of native coronary artery transplanted heart- w/o angina pectoris <input type="checkbox"/> - 125.812 Atherosclerosis of bypass graft of transplanted heart- w/o angina pectoris <input type="checkbox"/> - 125.89 Other forms of chronic ischemic heart disease <input type="checkbox"/> - 125.9 Chronic ischemic heart disease, unspecified <input type="checkbox"/> - Z95.1 Aortocoronary bypass graft	
<b>Stable Angina Pectoris</b> <input type="checkbox"/> - 120.1 Prinzmetal Angina Pectoris <input type="checkbox"/> - 120.8 Other forms of Angina Pectoris <input type="checkbox"/> - 120.9 Angina Pectoris - unspecified	<b>Post Heart Valve Transplant</b> <input type="checkbox"/> - Z94.1 Heart transplant status <input type="checkbox"/> - Z94.3 Heart and lungs transplant status	<b>Post Valve Repair or Replacement</b> <input type="checkbox"/> - Z95.4 Presence of other heart-valve replacement	<b>Post PTCA and/or PTCA/Stent</b> <input type="checkbox"/> - Z95.5 Coronary angioplasty implant graft <input type="checkbox"/> - Z98.61 Coronary angioplasty status  <b>Other</b> <input type="checkbox"/> - _____ ICD-10 Code

**Secondary Diagnosis:**

Hypertension  Hyperlipidemia  Obesity  Diabetes  Congestive Heart Failure

**Social History:**

Tobacco:  Current  Quit  Never Packs per day: \_\_\_\_\_

Type:  Cigarette  Cigar  Pipe  Smokeless Tobacco

**Physician Referral:**

I have examined the patient listed above and determined that his/her admission into the Cardiac Rehabilitation Program is medically necessary.

Physician's Name (please print): \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Office Phone#: \_\_\_\_\_ Office Fax#: \_\_\_\_\_

Please fax copy of cardiac stress test results, labs, medical history, face sheet, last progress note, and medication list to 620-724-5127.