Use Ballpoint Pen Only

Cardiac Rehabilitation Referral Form
364 White Oak Street
P.O. Box 1048
Asheboro, NC 27204-1048
Phone: (336) 633-7752
Fax: (336) 633-7750

Date: ______________________ Referring Practitioner Signature: ______________________

Patient Name: ______________________ Printed Practitioner Name: ______________________ ________ (date) ________ (time)

DOB: ______________________ Address: ______________________

Address: ____

______________________ Phone: ______________________

Phone: ______________________ Fax: ______________________

Cardiac Diagnosis: (Please provide ICD Code of diagnosis) - PLEASE CIRCLE APPROPRIATE DIAGNOSIS

________ S/P Myocardial Infarction (MI)/NSTEMI
________ S/P Coronary Artery Bypass Grafting (CABG)
________ Stable Angina Pectoris
________ Heart Valve Repair or Replacement
________ Percutaneous Transluminal Coronary Angioplasty (PTCA)/Coronary Stenting/Angioplasty
________ Heart or Lung Transplant
________ Heart Failure NYHA Class ________
________ Other ________

Medical Records required for admittance and chart completion

1. History and Physical
2. Discharge summary from most recent hospitalization
3. Cath report/Echocardiogram report
4. Medication list
5. Most recent office visit note
6. Lipid profile - preferably post event
7. Cardiac test - GXT / Nuclear within last 12 months

The Medical Director will order Cardiac GXT or Lipid profile for the participant if not available on admission.

☐ GXT-Grade Exercise Test ☐ Lipid Profile

Medical Director Signature: ______________________ ________ *(date)* ________ *(time)*

Medical Director Printed Name: ______________________

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CPREHABREFER