MOUNT AUBURN HOSPITAL

Outpatient Cardiac Rehabilitation Physician Referral Form

485

Patient Name: _____ DOB: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Diagnosis/Indication (Please indicate appropriate diagnosis)

- ❑ CHF if: EF ≤ 35% with symptoms (Please choose from the following)
  - ❑ **Patient shows no improvement despite being on optimal heart therapy for 6 weeks**.
    - ❑ *Class 2*: Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity
    - ❑ *Class 3*: Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (20-100m). Comfortable only at rest.
    - ❑ *Class 4*: Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients.
- ❑ Stable Angina
- ❑ MI (within past 12 months)
- ❑ Percutaneous Transluminal Coronary Angioplasty
- ❑ Coronary Stent
- ❑ Coronary Bypass
- ❑ Heart Valve Repair / Replacement
- ❑ Heart / Heart-Lung Transplant

Past Medical History: Please check all that apply

❑ CAD	❑ Diabetes	❑ Weight issues
❑ Angina	❑ HTN	❑ Joint or mobility problems
❑ Valve Disease	❑ Hyperlipidemia	❑ Anxiety or depression
❑ CABG	❑ Stress	❑ Vision or hearing problems
❑ Arrhythmias	❑ Smoking	❑ Pulmonary disease

Please attach a recent EKG, Stress test report, lipid profile, cath report, recent history and physical or recent discharge summary.

I have examined the patient named above and consent to have my patient participate in the cardiac rehabilitation program. I agree to have the patient counseled in all subjects related to cardiac rehabilitation such as risk factor reduction.

An exercise stress test is recommended prior to initiating cardiac rehab.

Additional information or instructions: _____

_____

_____

MD Signature: _____ Date: _____ Time: _____

MD Print Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____