

Cardiovascular Disease Prevention Center

25 New Chardon St.
Boston, MA 02114
Tel: 617-726-1843
Fax: 617-726-2203

MGH Cardiac Rehabilitation Referral

Please admit the following patient to the cardiac rehabilitation program.

Patient Name: _____ DOB: _____

Qualifying event: (please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Stable Angina |
| <input type="checkbox"/> Positive ETT | <input type="checkbox"/> Positive Cardiac Catheterization |
| <input type="checkbox"/> Coronary Artery Bypass Graft | <input type="checkbox"/> Valve Surgery |
| <input type="checkbox"/> PCI/PTCA | <input type="checkbox"/> Heart Transplant |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Other |

I agree to the evaluation of this patient for admission to the Cardiac Rehabilitation Program and understand that he (she) will continue all usual medical follow-up with me. Any changes in his (her) condition will be reported to me and that I will receive progress reports regarding this patient.

I also agree to the standing orders for Cardiac Rehabilitation below:

1. Admit to Outpatient Cardiac Rehabilitation
2. Nitroglycerine, 0.4 mg, s.l. for angina pain to a total of three doses. Call physician and transport to ER if pain unrelieved by three nitroglycerine.
3. In the event of a cardiac emergency follow ACLS protocol per MGH guidelines.

Please provide the following medical records. The patient cannot be admitted to Cardiac Rehabilitation until records are received.

Discharge summary

ETT

Patient is scheduled for an ETT on _____ OR please arrange ETT at MGH (imaging/non-imaging) please indicate.

Current lipid profile

Pertinent diagnostic tests (cardiac cath, ECHO etc)

Recent office note

Thank you.

Physician Signature: _____ Date: _____

Physician Name: _____

CR referral