



Cardiac Rehabilitation Department

PHYSICIAN REFERRAL FORM

Please check the required diagnosis on the **LEFT** and any additional diagnoses on the right as applicable

ICD 10	Description	ICD 10	Description
<input type="checkbox"/> I 20.9	Angina pectoris, unspecified	<input type="checkbox"/> E 11.9	Diabetes
<input type="checkbox"/> Z 95.5	Coronary angioplasty implant and graft	<input type="checkbox"/> Z 95.0	Cardiac pacemaker
<input type="checkbox"/> Z 98.61	Coronary angioplasty status	<input type="checkbox"/> Z95.810	Automatic (implantable) cardiac defibrillator
<input type="checkbox"/> Z 95.1	Aortocoronary bypass graft	<input type="checkbox"/> I 47.2	Ventricular tachycardia
<input type="checkbox"/> I 21.4	Acute non ST elevation MI	<input type="checkbox"/> I 48.2	Chronic atrial fibrillation
<input type="checkbox"/> I 21.3	ST elevation MI	<input type="checkbox"/> I 48.0	Paroxysmal atrial fibrillation
<input type="checkbox"/> I 50.22	Chronic systolic (congestive) heart failure **	<input type="checkbox"/> I 48.1	Persistent atrial fibrillation
<input type="checkbox"/> Z.95.2	Prosthetic heart valve	<input type="checkbox"/> I 51.81	Takotsubo syndrome
<input type="checkbox"/> Z 95.3	Xenogenic heart valve (tissue)	<input type="checkbox"/>	
<input type="checkbox"/> Z 94.1	Heart transplant status	<input type="checkbox"/>	

*** Stable, chronic heart failure (must meet requirements noted below)

1. LV EF of 35% or less and NYHA Class II to IV symptoms despite being on optimal heart failure therapy > 6 weeks.
2. Stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures.

PLEASE CHOOSE ONE:

- NO** exercise restrictions
- WITH** exercise restrictions Please explain: _____

CURRENT ETT (Post Intervention) IS STRONGLY RECOMMENDED TO DETERMINE EXERCISE PRESCRIPTION / INTENSITY

ETT Completed on _____ Date Circle one: results enclosed results will be sent

Schedule ETT with Thallium without Thallium

Pt cleared to enter Cardiac Rehab. ETT not indicated due to: _____ (must state a reason)

FASTING LIPID PROFILE IS REQUIRED WITHIN 6 MONTHS OF ENROLLING IN REHAB

ENCLOSED PLEASE SCHEDULE

IMPLEMENT THE FOLLOWING EMERGENCY ORDERS AS INDICATED:

- Initiate ACLS protocols in the event of patient code/collapse. Call Code or Rapid Response PRN.
- RN may advise patient to take their own sublingual NTG every 5 minutes x3 for angina
- Administer O₂ at 2 liters/min for angina as indicated
- Follow medical emergency guidelines as indicated
- Diabetics: administer 15mg Fast Acting Glucose Gel for BS < 100 before exercise, < 90 after exercise and prn for any hypoglycemic event

Physician Signature: _____ Date: _____ Time: _____
Print Name: _____ (required)