



**CORRIGAN MINEHAN  
HEART CENTER**

Cardiovascular Disease Prevention Center  
25 New Chardon Street, Suite 301 | Boston, MA 02114  
617 726 1843 | 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/TAVR               |
| <input type="checkbox"/> PCI/PTCA                     | <input type="checkbox"/> Heart Transplant                 |
| <input type="checkbox"/> CHF                          | <input type="checkbox"/> Other _____ (specify)            |

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

*Please sign this form and fax all requested medical records to 617-726-2203. Thank you*

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_