Garden City Hospital

Cardiopulmonary Rehabilitation Referral

Cardiac Rehab Order

(Ph) 734-458-3242 (Fx) 734-458-3538

Please check one:

[ ] *Phase I - Consultation* [ ] *Phase II -Cardiac Rehab* [ ] *HF Program*

Name:_____ DOB:_____ /_____ / _____

Phone:_____ Alternate Phone:_____

Diagnosis (circle all that apply): Myocardial Infarction Angina HF (acute or chronic)

CABG (# of Vessels:_____) PTCA/Stent

Valve Repair/Replacement (location:_____) **Event Date:____ /_____ / _____**

Based upon evaluation of current health status, please have patient exercise with the following restrictions:

[ ]No Restrictions [ ]Weight Limit:_____ Lbs. [ ]Other:_____

√ 6 Week Heart Failure Education Classes to be completed prior to the start of the Heart Failure Program

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Please include the following records with the completed referral and fax to Health Enhancement Center:

- Demographic information
- Copy of insurance card
- Most recent office visit note
- 12 lead EKG
- Stress test results (please include worksheet & peak EKG)
- Lab work
- Cath / Operative report
- Pacemaker / AICD setting information

I consent to have my patient participate in the exercise program specified above at Garden City Hospital's Health Enhancement Center. I agree to have my patient counseled I all subject areas related to the program he/she is enrolled in. I will continue the regular care of the patient throughout his/her participation in the program.

Physician Name:_____ **Phone:**_____

Physician Signature:_____ **Date:____ /_____ / _____**

(No signature stamps. Must be original signature.)