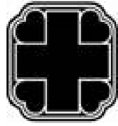

Beaufort Memorial HOSPITAL

# Cardiac Rehab Physician Referral

| **Patient Information** | | **Pt Acct #:** |
|---|---|---|
| **Patient Name (Last, First, MI)** | | |
| **Address:** | | |
| **DOB** | **Sex** ☐ **M** ☐ **F** | **Patient SS#** |

**Referral For**: ☐ Cardiac Rehab Phase II

**Diagnosis**: ☐ MI (I21.3) ☐ CABG (Z95.1) ☐ PTCA/STENT (Z98.61)

☐ Valve Replacement (Z95.2) ☐ Stable Angina (I20.8) ☐ CHF - Systolic (I50.22)* w/ EF% ______

☐ CHF – Diastolic (I50.32)* w/ EF% ______ ☐ CHF- Combined (I50.42)* w/ EF% ______

☐ Other ______________________________

**Diagnosis Date:** ______________________ ***Please include NYHA class for CHF dx**

**Medical History**: ______________________________

______________________________

| **Has this patient had:** | **YES** | **NO** |
|---|---|---|
| **History & Physical** | ☐ | ☐ |
| **Recent Office Visit** | ☐ | ☐ |
| **EKG** | ☐ | ☐ |
| **Surgery Reports** | ☐ | ☐ |
| **Lipid Profile** | ☐ | ☐ |
| **Blood Sugar (Glucose)** | ☐ | ☐ |
| **PFT** | ☐ | ☐ |

`

**NOTE: Please send copies of these reports if available.**

**SPECIAL INSTRUCTIONS**: ______________________________

______________________________

**Physician's Signature:** ______________________ **Date/ Time:** ______________________

**Printed Name:** ______________________

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Reviewed: 11/18