University Hospitals
Harrington Heart & Vascular Institute

Cardiac Rehabilitation
Physician Referral Form

Patient Name: _____ MRN: _____ Phone # _____

Address: _____
Street City State Zip

Diagnosis: (please check one of the following diagnoses)
Based on guidelines from the Center for Medicare & Medicaid Services, the following diagnostic criteria and/or ICD-9 codes are covered when referring patients to the Phase II Cardiac Rehabilitation Program:

____ Myocardial Infarction within past 12 months (410.00-410.92, 414.8)

____ Stable Angina Pectoris (413.00 – 413.9)

____ Percutaneous Transluminal Coronary Angioplasty or Stenting (V45.09 – V45.82)

____ Coronary Artery Bypass Surgery (V45.81) ____ Heart or Heart Lung Transplant (V42.1)

____ Heart Valve Repair or Replacement (V15.1,V42.2, V43.3) _____ Other Diagnosis

I authorize the Cardiac Rehabilitation Department to:

- Schedule a symptom limited graded exercise test with 12 lead ECG prior to starting cardiac rehabilitation and at discharge, if needed.
- Current lab values are helpful in order to assess the lipid status and individualized diet therapy. A venous blood sample will be drawn and lipids analyzed at the UH laboratory.

To ensure CMS compliance and development of the patients Individualized Treatment Plan (ITP), the following options are available, **please check appropriate below**:

____ Defer the patient's ITP and exercise prescription to be developed by the staff for your review and approval (see physician portal for guidelines and resources).
____ Request the Medical Director to share responsibility for developing an ITP and exercise prescription for your patient only during enrollment in the phase II program.
____ Establish my own ITP and exercise prescription (document recommendations below).

_____

I consent to have my patient participate in the cardiac rehabilitation program. I will continue regular medical care of my patient throughout his/her participation in the program. I agree to have my patient participate in the outpatient (phase III) cardiac rehabilitation program after completion of the phase II program.

Name of Physician (please print) _____

Date: _____ MD/DO Signature: _____

Questions, please contact Dr. Josephson @ (216) 844-2775 or richard.josephson@UHhospitals.org
Please fax completed forms and reports to**:**

Rev 2/12 **UH Chagrin/Highlands Health Center at (216) 201-5134**