Referral for Intensive Cardiac Rehab

Phone: 866-932-5104 Fax: 888-906-4080

Section 1: Patient Information

Patient Name: _____

Patient Number: _____ Patient DOB: _____

Section 2: Qualifying Diagnosis

Please provide the DX Code and qualifying diagnosis.

DX Code: _____

Diagnosis: _____

Section 3: Physician Information

Physician Name: _____ Signature: _____

Office Number: _____ Fax: _____

Email (For Referral Updates): _____

Referral Date: _____

Section 4: Additional Information

Please include any of the following information:

- Office Notes Specific to Cardiac or Pulmonary Event/Condition
- EKG, Echocardiogram, Stress Test and Catheterization Report (If Available)
- Discharge Summary (If Available)
- Any Additional Relevant Medical History, Including Medication List (If Not Included In Office)