Telemedicine Cardiac Rehabilitation

Fax to: 410-871-4022

REFERRAL FORM

PATIENT NAME: _____ DOB: _____

PHONE: _____

EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

CARDIAC DIAGNOSIS:

- ☐ S/P MI
- ☐ S/P Stent
- ☐ S/P CABG
- ☐ S/P Valve Procedure
- ☐ Stable Angina
- ☐ CHF (EF < 35%)
- ☐ S/P Cardiac Transplant

DOES this patient have any of the following high risk characteristics:

- Angina at low workload
- Total functional capacity < 3 mets
- Serious unstable arrhythmias
- Sudden death
- EF < 35%
- Recent Complicated MI
- NYHA class 4 CHF

- ☐ **Yes**
- ☐ **No**

PROVIDER SIGNATURE: _____

Please Print Name: _____

PHONE #: _____

FAX #: _____