Use Ballpoint Pen Only

Cardiac Rehabilitation Referral Form
364 White Oak Street
P.O. Box 1048
Asheboro, NC 27204-1048
Phone: (336) 633-7752
Fax: (336) 633-7750

Date: _____ Referring Practitioner Signature: _____

Patient Name: _____ Printed Practitioner Name: _____ _____ _____
(date) (time)

DOB: _____ Address: _____

Address: _____

_____ Phone: _____

Phone: _____ Fax: _____

Cardiac Diagnosis: (Please provide ICD Code of diagnosis) - PLEASE CIRCLE APPROPRIATE DIAGNOSIS

_____ S/P Myocardial Infarction (MI)/NSTEMI
_____ S/P Coronary Artery Bypass Grafting (CABG)
_____ Stable Angina Pectoris
_____ Heart Valve Repair or Replacement
_____ Percutaneous Transluminal Coronary Angioplasty (PTCA)/Coronary Stenting/Angioplasty
_____ Heart or Lung Transplant
_____ Heart Failure NYHA Class _____
_____ Other _____

Medical Records required for admittance and chart completion

1. History and Physical
2. Discharge summary from most recent hospitalization
3. Cath report/Echocardiogram report
4. Medication list
5. Most recent office visit note
6. Lipid profile - preferably post event
7. Cardiac test - GXT / Nuclear within last 12 months

The Medical Director will order Cardiac GXT or Lipid profile for the participant if not available on admission.

☐ GXT-Grade Exercise Test ☐ Lipid Profile

Medical Director Signature: _____ _____ _____
(date) *(time)*

Medical Director Printed Name: _____