

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: _____ Fax: _____

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: _____



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CPREHABREFER



Revised 07/2026
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