Cardiopulmonary Rehab Services
1855 South Main St., Suite B
Goshen, IN 46526
Office 574-364-2587 Fax 574-364-2531

Patient Name ____________________	Ordering Physician Signature ____________________
Date of Birth __________ Social Security __________	Ordering Physician ____________________
Address ____________________	
City __________ State ______ Zip ______	Primary Care Physician ____________________
Telephone # ____________________	Send Copy To ____________________
	Fax Results To ____________________
Primary Insurance ____________________	
Primary Policy # __________ Group # ______	Diagnosis #1 __________ ICD-10 Code __________
	Diagnosis #2 __________ ICD-10 Code __________
Secondary Insurance ____________________	Diagnosis #3 __________ ICD-10 Code __________
Secondary Policy # __________ Group # ______	Diagnosis #4 __________ ICD-10 Code __________

Cardiac Rehabilitation Referral Form

Date of referral: ______________________

Date of qualifying event: ________________

❑ Cardiac Rehab

For required safety and admission qualifications, I authorize the following:

- Rehab staff to develop Individualized Treatment Plan/Exercise Rx for Medical Director to review and approve on admission to the program and every 30 days until discharge from program
- 6 Minute Walk Test pre and post program
- Cardiopulmonary Stress Test pre-program (as indicated by HF stratification)
- 12 Lead EKG within 3 months of the qualifying event

❑ Intensive Cardiac Rehab *(Ornish Lifestyle Medicine)*

For required safety and admission qualifications, I authorize the Cardiac Rehab requirements listed above, in addition to:

- Labs pre program (if no draw in the past 3 months) and post program including lipids, HgbA1c and hsCRP
  - ✓ **Diagnosis #1 ____________ICD-10 Code ______________**
  - ✓ **Diagnosis #2 ____________ICD-10 Code ______________**

I hereby certify that the above patient is medically able to participate in Cardiac Rehab.

PLEASE FAX COMPLETED FORM TO 574-364-2531