Wuesthoff Cardiac Rehabilitation
Exercise Program Phase II
Physician Referral
Phone (321) 636-2052
Fax (321) 636-6481

Referring Physician_____ Date_____

Patient Name_____ Phone_____

Diagnosis:

____CAD / Myocardial Infarction – 410 ____Other_____

____CAD / Stable Angina – 413.9

____CAD / Aortocoronary Bypass Surgery – 414.0/V45.81

____ CAD / PTCA/ Stent Placement – 414.0/V45.82

____ Mitral Valve Disorders/ Valve Replacement or Repair – 424.0/V43.3

____ Aortic Valve Disorders/ Valve Replacement or Repair – 424.1/V43.3

____ Valve Disorders/ Valve Replacement or Repair – 424.2/V43.3

Date of Illness_____ Hospital_____
(Referral effective for one year from date of illness above)

MedicalHistory_____

Comments_____

Procedures to include:
Blood Pressure Monitoring
Continous Telemetry Monitoring
O2 Sat prn
Simple Six minute walk test if necessary

Based upon known medical/surgical history of the above patient, I am of the opinion he/she is capable of participating in the Cardiac Rehabilitation program.
** Pt to be stratified as High Risk, will be adjusted prn after admission assessment**

Signature_____ Date_____