Cardiac Rehabilitation Program Physician Order Form to Consult and Treat

Patient’s Name: [ ]
DOB: [ ]
MR#: [ ]

**Diagnosis:** (Please check all that apply)
- [ ] NSTEMI I21.4
- [ ] STEMI
  - [ ] left main I21.01
  - [ ] LAD I21.02
  - [ ] RCA I21.11
  - [ ] LCx I21.21
  - [ ] Other anterior I21.02
  - [ ] Other inferior I21.19
  - [ ] Other I21.29
  - [ ] Unspecified I21.3
- [ ] Stent/Angioplasty Z98.61
- [ ] CABG Z95.1
- [ ] Valve replacement Z95.3

- [ ] CHF NYHA Class ____ EF ____
  - [ ] Clinically stable on optimized medical treatment
    - [ ] Systolic HF I50.22
    - [ ] Diastolic HF I50.32
    - [ ] Unspecified I50.9
- [ ] Angina I20.9
- [ ] Heart Transplant Z94.1
- [ ] Other (valve repair, valvuloplasty, aortic aneurysm repair, aortic root repair/replacement) Z98.89
- [ ] Other: ____________________________

(Diagnoses other than listed above will not be covered by Medicare)

Date of Diagnosis (if known): [ ]

**Disease Related Complications/Exercise Limitations:**

Cardiac Rehab Exercise Protocol:
- [ ] Frequency: 36 sessions
  - Date range of referral _______________________
- [ ] Duration: 31-60 minutes per session
- [ ] Type: aerobic exercise to include track walking, treadmill, bicycle, nustep, elliptical machine, and/or arm ergometer
- [ ] Intensity: 40-85% of peak heart rate reserve
- [ ] RPE: 11-14 (Borg 6-20 Scale)

Please indicate any individual changes needed to be made to exercise prescription:

I have examined the above patient and have found him/her medically qualified to participate in the above ordered activities.

__________________________
Physician Name (Please Print)  Note: Must be a MD/DO

__________________________
Physician Signature

__________________________
Physician Contact Number

__________________________
Physician Signature

Date/Time Signed