



**Patient Information (Required for Scheduling)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F SS#: XXX-XX-\_\_\_\_\_  
First & Last Name

Patient's Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone #: \_\_\_\_\_ Mobile Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Plan & Product

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Plan & Product

**Order Information - Cardiac Rehabilitation**

**Outpatient Cardiac Rehabilitation – Phase II (CPT 93798)**

**Diagnosis (please check all that apply):**

Note: Medicare will ONLY cover the following diagnoses.

- |                               |   |
|-------------------------------|---|
| <input type="checkbox"/> MI   | <input type="checkbox"/> Stable Angina            |
| <input type="checkbox"/> CAD  | <input type="checkbox"/> Heart Transplant         |
| <input type="checkbox"/> PTCA | <input type="checkbox"/> Valve Repair/Replacement |
| <input type="checkbox"/> CABG | <input type="checkbox"/> CHF (EF≤35%)             |

Other (please specify): \_\_\_\_\_

ICD-CM Codes for Selected Diagnosis and Other: \_\_\_\_\_

**Please include the following information with this referral:**

- Medical History/Physical and/or Discharge Summary
- Stress Test Results (if available)
- Resting 12-Lead ECG (most recent, if available)
- Lipid Profile Results (if available)
- CABG or PTCA Report
- Current Medication List

The above patient may participate in **Outpatient Cardiac Rehabilitation** consisting of EKG monitored exercise and personal risk modification instruction.

- Patient may participate in outpatient Cardiac Rehabilitation following stress test.**  
Stress test results are included with this referral.
- Patient may participate in outpatient Cardiac Rehabilitation without stress test.**  
Exercise to a heart rate of resting plus 20 beats/minute (or Target Heart Rate of 60-85%) and/or rate of perceived exertion of 11-14 on Borg scale (6-20).

**Referring Physician Information**

Physician Name (first & last): \_\_\_\_\_ NPI#: \_\_\_\_\_ GA License #: \_\_\_\_\_

Physician Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_