

# Straub Benioff Cardiac Rehabilitation

healthier

## REFERRAL FORM

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

**Please fax to 808-522-4134.**

Please select at least one of the following and add in the ICD code that most relates to diagnoses:

**Post-Myocardial Infarction (MI) – within the past 12 months: ICD code \_\_\_\_\_**

Date: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)

**Cardiac surgery/procedures: ICD code \_\_\_\_\_**

Date: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)

- Coronary artery bypass surgery
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart or heart-lung transplant

**Stable angina: ICD code \_\_\_\_\_**

**Diagnosed with stable, chronic heart failure (CHF): ICD code \_\_\_\_\_**

- Patients with a left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms, despite at least six weeks of optimal heart failure medical therapy.

**\*EXCLUSIONS: Current substance or drug abuse, or a history of psychiatric disorder without documentation of at least one year of stability.**

I authorize my patient to enroll in the Straub Benioff Medical Center Outpatient Cardiac Rehabilitation Program.  
I understand that I will continue to provide regular medical care to my patient throughout the duration of the program.

**Please fax the following patient information below with this form to 808-522-4134:**

- Latest lab results for lipid panel and hemoglobin A1c
- Echocardiogram results
- Progress notes
- Electrocardiogram (EKG) tracing
- Stress test summary

**For questions, call 808-522-4114.**

Name of Physician (please print): \_\_\_\_\_

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

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