Hackensack Meridian
Mountainside Medical Center

1 Bay Ave Montclair, NJ 07042

CARDIAC REHABILITATION REFERRAL Dr._____

Phone Number 973-429-6199 Fax Number 973-680-7741

Date: _____

PATIENT NAME: _____DOB_____

ADDRESS: _____

PHONE: _____

DIAGNOSIS/DATE: _____

☐**CABG**: Z95.1 ☐**STABLE ANGINA**: I20.9 ☐**HEART TRANSPLANT**: Z94.1 ☐**VALVE REPLACEMENT**: Z95.2

☐**VALVE REPAIR**: Z98.89 ☐**PCI/STENT**: Z95.5 ☐**PTCA**: Z98.61 ☐**≤ 4wks post STEMI**: I21.3 ☐**non STEMI**: I21.4

☐**> 4wks post MI**:Z51.89 ☐ **Stable Chronic HF**: I50.22 other_____

For CHF all criteria must be met: EF ≤ 35%_____ (**send documentation**) NYHA class II-IV_____

Optimal medical therapy x 6wks _____ No planned cardiovascular procedures for at least the next 6 months____

PRESCRIBED TREATMENT

PHASE II – MONITORED

LENGTH OF STAY IN PROGRAM

____ FAST TRACK = 4-6 weeks (18 sessions) ___ DX: Uncomplicated MI, PTCA, Stent

CRITERIA: EF>50%, No Complex Dysrhythmias, No CHF or Angina

____ SLOW TRACK = 12 weeks (36 sessions)

INTENSITY

____ From recent stress test, 70-85% of the Max HR = THR range

____ No recent stress test, resting HR +20-40bpm = THR range

____ Patient's rating of perceived exertion (RPE) = 11-14 BORG scale

DURATION: Progress exercise 20-40 minutes per protocol

FREQUENCY: Schedule exercise sessions 3 X per week

NUTRITIONAL CONSULTATION: _____

PLEASE SEND COPIES OF: EKG, CBC, LYTES, LIPIDS, MEDICATION LIST, STRESS TEST (if necessary)

____I authorize cardiac rehab to order the tests indicated below that were not performed in the last 6 months:

___EKG, ___CBC, ___LYTES, ___LIPIDS

PHASE III/PHASE IV - _____ NON-MONITORED (intermittent rhythm strips & BP's)

ALL TREATMENT PROGRAMS ARE DESIGNED TO FACILITATE MAXIMUM FUNCTION. THIS PRESCRIPTION SERVES AS A STATEMENT OF MEDICAL NECESSITY FOR THE ABOVE MENTIONED PATIENT.

PHYSICIAN SIGNATURE:_____ Phone #_____

PHYSICAN NAME (PLEASE PRINT):_____