Methodist Methodist West Houston Hospital

Cardiac Rehabilitation Program Referral Form

Patient Name: _____ _____
Last First MI DOB

Home Phone: (_____) _____ Day Phone: (_____) _____

Patient Primary Insurance: _____

I am referring my patient to The Methodist West Houston Cardiac Rehabilitation Program for:

- ☐ Initial Prescription for Cardiac Rehabilitation. (36 sessions)
- ☐ Cardiac Rehabilitation Prescription Renewal additional 12, 24, 36 sessions (circle one)

Medical Justification for renewal required: _____

Physicians: Please attach the following information to the referral, if available. **This will assist us with patient care, insurance reimbursement and patient outcomes.**

1. Hospital discharge summary, H & P or office note summarizing patient status.
2. **Resting 12 lead EKG.**
3. **Lipid Profile** and other lab reports.
4. **Recent graded exercise test (within 3 months).**
5. Heart catheterization report.
6. Echocardiogram report.

Diagnosis: Please indicate conditions that apply to your patient:

Phase II

☐ s/p CABG	Date:_____
☐ s/p MI (within the last 12 months)	Date:_____
☐ s/p PCI	Date:_____
☐ s/p AVR / MVR	Date:_____
☐ s/p Heart or Heart/Lung Transplant	Date:_____
☐ Stable Angina	

Current Medications: _____

_____

Special Instructions for attending staff: _____

_____ _____ _____
Physician's Name **Physician's Signature** **Date**

_____ _____
Address **Physician's Phone**

_____ _____
City **State** **Zip** **Physician's Fax**

Return To: Cardiac Rehabilitation- Methodist West Houston Hospital
Fax: 832-522-3081

Phone: 832-522-CARD(2273)