

Elizabethtown Community Hospital

CARDIAC REHABILITATION Physician Referral Form

I have referred and cleared the following patient to begin Phase 2 cardiac rehabilitation for monitored exercise, risk factor modification, and heart disease education.

Patient's Name: _____	Patient's Address: _____
DOB: _____	_____
Phone: _____	_____

DIAGNOSIS: PATIENT MUST HAVE A DATED DIAGNOSIS TO ENTER PROGRAM

STEMI (date): _____	NSTEMI (date): _____
CABG (date): _____	_____
Valve Repair (date): _____	Valve Replacement (date): _____
PTCA (date): _____	CORONARY STENTING (date): _____

Heart Transplant

Heart Failure (date of onset): _____ **NYHA Classification:** II III IV EF _____ %

CURRENT STABLE ANGINA: (date of onset): _____

Limitations set by referring physician (if any): _____

Referring Physician's Office Contact Information

Practice Name _____

Address _____ Phone Number _____

_____ Fax Number _____

Physician Signature: _____ Date: _____

Physician Name (please print): _____



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