Name:_____ **Contact#:**_____

DOB:_____

CARDIAC REHABILITATION−please check diagnosis

	Diagnosis	Date
☐	Stable Angina Pectoris	_____
☐	Myocardial Infarction	_____
☐	Heart or Heart−Lung Transplant	_____
☐	Heart Valve Repair/Replacement	_____
☐	Coronary Artery Bypass Graft	_____
☐	PCI/Stent	_____
☐	Stable* Chronic Heart Failiure	_____

(LVEF 35% or less and NYHA class II−IV symptoms despite being on optimal heart failure therapy for at least 6 weeks)
*Stable−patient **has not** had recent (less than 6 weeks) or planned (less than 6 months) major cardiovascular hospitalizations or procedures.

Risk Stratification−please check appropriate risk for the occurrence of a cardiac event during exercise.

☐ Low Risk ☐ Moderate Risk ☐ High Risk

Physician Statement and Plan of Treatment: Frequency:3 days per week Sessions:1−2 per day

● I have examined the above patient and have determined admission into cardiac rehabilitation is medically necessary. Patient's exercise program will be established, reviewed and updated by the Medical Director and staff. Discharge is dependent upon progress and completion of established goals;an outcome assessment will then be completed. After discharge, I agree with patient's participation in the maintenance program.

● I understand the program will consist of an individualized exercise plan (aerobic and resistance training), nutritional assessment and counseling, psychosocial assessment (counseling if necessary), smoking cessation (if necessary) and vocational rehabilitation (if necessary) to achieve individualized goals.

● I understand patient may receive education and training on the following but not limited to: Anatomy and physiology, nutrition, medications, exercise, risk factors for heart disease and relaxation exercises. Patient will be monitored with continuous electrocardiography and/or pulse oximetry (intermittent or continuous). A six minute fitness test along with various balance and strength tests to be done depending on the severity of the disease.

● I understand patient is to self−report glucose values and staff is to use hospital glucometer during emergencies or if patient does not have or bring their own.

_____ _____

Physician Signature (MD or DO only) **Date/Time**

_____

Printed Name

Return Fax Number:
910−897−5902

Harnett Health System

CARDIAC REHABILITATION OUTPATIENT ORDER

CARR−ORDER
R:08/15

P0