Beaufort Memorial Hospital

Cardiac Rehab Physician Order

Pt Acct #:___________________

Patient Information			General Instructions
Patient Name (Last, First, MI)			All orders must include an ICD-9 code or diagnosis. Test not covered by that code may be charged to the patient. Please fill in the appropriate code or diagnosis for each test
Address:			
DOB	Date	Sex ☐ M ☐ F	
Referring Physician Signature		Patient SS#	

Referral For: ☐ Phase II ☐ Phase III ☐ Phase IV

Note: A minimum of one month of Phase III participation is required prior to entry into Phase IV.

Diagnosis: ☐ MI ☐ CHF ☐ PTCA ☐ CABG ☐ Stable angina ☐ Stent ☐ CAD

☐ Other: ____

Medical History:____

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Has this patient had:	YES	NO	DATE
History & Physical	☐	☐	____________
Recent Office Visit	☐	☐	____________
EKG	☐	☐	____________
Graded Exercise Test (GXT)	☐	☐	____________
Cardiac Catheterization	☐	☐	____________
Cardiac Surg/Intervent Report	☐	☐	____________
**Lipid Profile	☐	☐	____________
CBC	☐	☐	____________
Electrolytes	☐	☐	____________
Blood Sugar (Glucose)	☐	☐	____________
PFT	☐	☐	____________

NOTE
Please send copies of these reports if available

* A GXT is required prior to entry in Phase III, and suggested prior to entry into Phase II. If unavailable, I authorize a GXT be performed at Beaufort Memorial Hospital under the direction of the Cardiac Rehabilitation Medical Director: ☐ ☐

☐ **A GXT IS NOT REQUIRED PRIOR TO ENTRY INTO PHASE II.**

**Lipid profile pre-cardiac event or six or more weeks post event. If not available, I authorize that necessary labs be obtained at Beaufort Memorial Hospital. ☐ YES ☐ NO

SPECIAL INSTRUCTIONS:____

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Physician's Signature: ____

Physician's Phone#: ______________________ Date: ______________________

Physician's Mailing Address:____

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