CARDIAC REHAB - CHATT - ECP REFERRAL FORM

Cardiac Rehabilitation Phone: (530) 626-2766 Fax: (530) 621-4216
CHATT & ECP Phone: (530) 626-2850 Fax: (530) 621-4216

MARSHALL MEDICAL CENTER

Patient Name: _____ DOB: _____

Patient Phone: _____ MD: _____

☐ **Pritikin Intensive Cardiac Rehabilitation**

☐ Monitored Program: (up to 72 sessions / 18 weeks telemetry monitored exercise and education sessions)

Dx: ☐ must be within the previous 12 months MI _____ (date) ☐ CABG _____ (date)

☐ Stable Angina ☐ PTCA/STENT_____(date) ☐ CHF (≤ 35% EF NYHA Class II to IV symptoms)

☐ Heart Valve Repair/Replacement _____(date) ☐ Other CV Dx _____

☐ Heart/Lung Transplant _____(date) ☐ ICD Code(s) _____

Please enclose copies of the following records with referral.

REQUIRED FOR ENROLLMENT EVALUATION

- H&P • Cath Report • Op Report • D/C Summary • EKG (post proc/event)
- Labs (to include Lipid & Chem panel, CBC & HbA1c) • Stress Test
- Recent Office Notes • Insurance Card Copy (front & back) • CXR

☐ **E.C.P. - External Counterpulsation Therapy: For stable Angina**

35 one hour sessions (5 days per week for 7 weeks). *If patient needs screening for aortic valve competency, AAA or DVT, please order.*

☐ **CHATT - Congestive Heart Active Telephone Treatment**

(CHF Disease Management - self-pay program)

☐ Implement Protocol Diagnosis: _____

☐ Perform EKG on admission to Cardiac Rehab and PRN arrhythmia

Physician Signature: _____ Date/Time: _____