CARDIAC REHABILITATION REFERRAL ORDER

I am referring my patient, _________________________________ to:

______ PHASE 2 (Monitored Phase) Medically supervised exercise with continuous ECG monitoring

______ PHASE 3 (Maintenance Phase) Medically supervised exercise and ECG monitoring as needed

I certify that this rehabilitation program is medically necessary for my patient due to patient history and following diagnosis:

☐ Post Coronary Artery Bypass Surgery (Date _________ )
☐ Valve Repair/ Replacement (Date _________ )
☐ Post Percutaneous Transluminal Coronary Angioplasty (Date _________ )
☐ Post Myocardial Infarction (Date _________ ) (*MI must be within 12 months per Medicare coverage guidelines)
☐ Stable Angina Pectoris ☐ Heart Failure / Cardiomyopathy ☐ Other __________________________

An exercise prescription will be developed for your patient using ACSM and AACVPR guidelines in the table below. If there are any instructions and/or changes that you wish to add to the prescription, please indicate in the comments section below.

<table>
<thead>
<tr>
<th>Exercise Progression Plan</th>
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<tbody>
<tr>
<td>Frequency: 3 days / week</td>
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<tr>
<td>Intensity: Increase MET level based on 11-13 RPE, BP, HR, signs or symptoms</td>
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<td>Time: Up to 45 minutes per session</td>
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<tr>
<td>Modality: Aerobic, continuous, dynamic (Based on ACSM 7th ed. &amp; AACVPR 4th ed.)</td>
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</tbody>
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Comments or changes to exercise prescription: __________________________________________________________

Physician
Signature: __________________________ Date: __________ Time: __________

Physician Printed Name: __________________________

Vinings Cardiac Rehabilitation
A Service of WellStar Cobb Hospital
4441 South Atlanta Road, Suite 114
Smyrna, GA 30080
(470) 956-0420
Fax (678) 842-5531

Douglas Cardiac Rehabilitation
8954 Hospital Dr.
Douglasville, GA 30134
(770) 920-6425
Fax (770) 920-6417

Kennesstone Cardiac Rehabilitation
330 Kennesstone Hospital Blvd.
Marietta, GA 30060
(770) 793-7455
Fax (770) 793-7456

Paulding Cardiac Rehabilitation
A Service of WellStar Paulding Hospital
144 Bill Carruth Parkway, Suite 1200
Hiram, GA 30141
(470) 644-8030
Fax (470) 644-7365

South Cherokee Cardiac Rehabilitation
A Service of WellStar Kennestone Hospital
120 Stone Bridge Parkway, Suite 110
Woodstock, GA 30189
(678) 324-4409
Fax (678) 445-1330

East Cobb Cardiac Rehabilitation
A Service of WellStar Windy Hill Hospital
3747 Roswell Road, Suite 114
Marietta, GA 30062
(470) 956-0180
Fax (678) 560-5951