



## CARDIAC REHABILITATION REFERRAL FORM

The patient named below is referred for Cardiac Rehabilitation:

Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Medical Insurance Company (*please include number*) \_\_\_\_\_

CPT CODE (*check one*)

- 93798 Cardiac Rehab with continuous monitoring
- 93797 Cardiac Rehab without continuous monitoring

Diagnosis: (*please check all that apply*)

- Stable Angina
- Coronary Artery Bypass Surgery Date: \_\_\_\_\_
- Myocardial Infarction (within the last 12 months) Date \_\_\_\_\_
- Percutaneous Transluminal Coronary Angioplasty
- Coronary Stenting
- Cardiac Valve Disease (valve replacement or valve repair) Date \_\_\_\_\_
- Heart Transplant
- Other \_\_\_\_\_
- Known Drug Allergies \_\_\_\_\_

(Attach any other pertinent medical documents if necessary)

\_\_\_\_\_  
*Name of Referring Physician (Print)*

\_\_\_\_\_  
*Signature of Referring Physician*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Contact/Office Number*

\_\_\_\_\_  
*Pager Number*

**Please send or fax form to:**  
Cardiac Rehabilitation Program  
3-East Suite 28  
Office: 202 865-5380 ~ Fax: 202-865-6565