METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

Heart & Vascular

Referral for Phase II Cardiac Rehabilitation

Patient information – Please fill out completely

Patient's Name (Last, First) _____

Patient's Date of Birth _____

Referral Information

Diagnosis / ICD:10

☐ Acute myocardial infarction (STEMI)
☐ Acute myocardial infarction (NSTEMI) (I21.4)
☐ Cardiac transplantation (Z 94.1)
☐ Cardiac valve surgery (or repair) (Z 95.2)
☐ Chronic heart failure (EF ≤ to 35%) (I50.22)
☐ Coronary angioplasty or stenting (Z 95.5)
☐ Coronary artery by-pass surgery (Z 95.1)
☐ Stable angina (I20.9)
☐ Other_____

I wish to refer this patient to Cardiac Rehabilitation Services and:

☐ I have seen and examined this patient, and believe he/she is ready to participate in Cardiac Rehabilitation.

☐ I believe this patient is surgically stable and able to begin rehab after review by _____

_____
Physician signature

_____
Physician name (print)

_____
Time Date

10/17

Heart & Vascular
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