



Phase II Cardiac Rehabilitation Referral/Order Form
Please fax this form & the patient's most recent Insurance/Demographic data to the appropriate location listed below.

Patient Name: _____ DOB: _____ Date/Time: _____

Traditional Cardiac Rehabilitation (TCR)

Diagnosis (please check one of the following diagnoses): Based on guidelines from the Center for Medicare and Medicaid Services (CMS), the following diagnostic criteria and/or ICD-10 codes are covered when referring patient to the **Traditional Cardiac Rehab**

<input type="checkbox"/> MI (STEMI) I21.3 Date: _____ <input type="checkbox"/> MI (Non-STEMI) I21.4 Date: _____ <input type="checkbox"/> OLD MI (>8 Weeks) I25.2 Date: _____ <i>(w/in 12 months of infarction)</i>	Valve Surgery – Specify Valve <u>and</u> procedure <input type="checkbox"/> I34.9 (MV) <u>or</u> <input type="checkbox"/> I35.9 (AV) <input type="checkbox"/> Z95.3(Transpltd Tissue) <input type="checkbox"/> Z95.2 (Prosthetic) <input type="checkbox"/> Z98.89 (Repair) Date: _____
<input type="checkbox"/> Angina Pectoris I20.9 Date: _____ PTCA/Stent I25.10 & Date: _____ <input type="checkbox"/> Z95.5 (Presence of implant/graft) <input type="checkbox"/> Z98.61 (No implant/graft)	<input type="checkbox"/> CABG Z95.1 & I25.10 Date: _____ <input type="checkbox"/> Heart Transplant Z94.1 Date: _____
<input type="checkbox"/> Heart Failure I50.22 Date: _____ Heart Failure Qualifying Criteria (Please complete ALL criteria fields) LVEF = _____ *must be \leq 35% NYHA Class II to IV on optimal heart failure therapy for at least 6 weeks (Circle class): Class II Class III Class IV Stable Chronic Heart Failure i.e. No recent (< 6 weeks) or planned (< 6 months) major cardiovascular hospitalization or procedure: <input type="checkbox"/> Yes Date of hospitalization/procedure _____ <input type="checkbox"/> No	
<input type="checkbox"/> VAD/MCS Z48.812 Date: _____ <small>(Encounter for surgical aftercare following surgery on the circulatory system)</small>	<input type="checkbox"/> Other Diagnosis <u>with</u> ICD-10 _____ Date: _____

Treatment Plan

- Outpatient Monitored Cardiac Rehab, duration based on patient progress 2-3 times per week up to a total of 36 sessions over a maximum of 36 weeks for TCR.
 - Progressive exercise training 2-3 times per week, 30-60 minutes per session, utilizing cardio, other conditioning activities and appropriate home program supplement.
 - Initiation of light upper/lower body resistance training with progression as tolerated and as specific to patient needs
 - Education/coaching to promote an active healthy lifestyle and reduction of personal cardiovascular risk factors.
- Exercise Tolerance evaluation (including sub-max treadmill, 6MWT, or Duke Activity Index Status) for exercise prescription
- Appropriate monitoring of BS for diabetes and referral to diabetes education as indicated.
- Initiate all emergency protocols as indicated.
- Initiate O₂ with exercise as indicated.
- Obtain 12-Lead EKG as indicated.
- Patient will be allowed to transition into Phase III (supervised, non-telemetry monitored) if patient is asymptomatic and progressing without problems

This patient is medically stable and cleared to begin cardiac rehabilitation.

Physician Printed Name	Physician Signature	Date /Time
1. Medical Park Tower (An outpatient department of <i>Seton Medical Center Austin</i>) 1301 W. 38th Street, Suite 510 • Austin, TX 78705 Phone (512) 324-1037 • Fax (512) 324-1896	4. Seton Medical Center Williamson 201 Seton Parkway • Round Rock, TX 78665 Phone (512) 324-4160 • Fax (512) 324-4688	
2. Seton Southwest Hospital • Health Plaza 2 (An outpatient department of Seton Southwest Hospital) 7900 FM 1826 • Austin, TX 78737 Phone (512) 324-9283 • Fax (512) 406-6527	5. Seton Highland Lakes Hospital (An outpatient department of Seton Highland Lakes Hospital) 200 John W Hoover Pkwy, Building 1B • Burnet, TX 78611 Phone (512) 715-3130 ext 66800 • Fax (512) 715-3197	
3. Seton Medical Center Hays 6001 Kyle Parkway • Kyle, TX 78640 Phone (512) 504-5129 • Fax (512) 268-8724		