Patient Name: DOB: Age: Sex: 410.90 MI Date: Phone: Cell number: V45.81 CABG Date: Address: 413.9 Stable Angina Date: V45.82 Angioplasty/Stent Date: V45.82 Angioplasty/Stent Date: Insurance Information: Heart Failure	100 Brown Street Chestertown, MD 21620 Phone: 410-778-3300, ex	300 By Cambr kt. 2222 Phone	//C at Dorchester /rn Street idge, MD 21613 : 410-228-5511, e 10-221-0771	21 Ext. 8201 P	M SMC at Easton 19 South Washington Street aston, MD 21601 hone: 410-822-1000, ext. 5208 AX: 410-763-8137	
Phone: Cell number: V45.81 CABG Date: Address: 413.9 Stable Angina Date: V45.82 Angioplasty/Stent Date: V45.82 Angioplasty/						
Address: 413.9 Stable Angina Date: V45.82 Angioplasty/Stent Date: V43.3 Valve Replacement Date: Insurance Information: Heart Failure LVEF < 35% / NYHA Class II-IV symptoms despite being on optimal heart failure therapy for at least 6 weeks. Stable No recent (< 6 weeks or planned < 6 months) major cardiovascular hospitalization or procedures. STRESS TEST – MUST BE PERFORMED POST EVENT WITHIN 6 MONTHS He/she does does not need a stress test prior to starting this program. Scheduled for: [Date] [Date] [Date] [Carlility] The program will be 1-5 times per week for up to 36 weeks. Modifications may occur due to individual risk stratification. Please refer to Nutrition Services as indicated. Special Instructions: Physician's Name (Please Print) Signature of Referring Physician Date	DOB:	Age: Se	x:	410.90 MI	Date:	
V45.82 Angioplasty/Stent Date:	Phone:	Cell number	·:	V45.81 CABG	Date:	
Insurance Information: Heart Failure LVEF < 35% / NYHA Class II-IV symptoms despite being on optimal heart failure therapy for at least 6 weeks. Stable No recent (< 6 weeks or planned < 6 months) major cardiovascular hospitalization or procedures. He/she does does not need a stress test prior to starting this program.	Address:			413.9 Stable Angir	na Date:	
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He/she does does not need a stress test prior to starting this program. Scheduled for: (Date) (Facility) The program will be 1-5 times per week for up to 36 weeks. Modifications may occur due to individual risk stratification. I have examined the above named patient and see no contraindications for participation in Phase II Cardiac Rehabilitation. Please refer to Nutrition Services as indicated. Special Instructions: Physician's Name (Please Print) Signature of Referring Physician Date	Insurance Information:			LVEF < 35% / N despite being on o least 6 weeks. Stable No recent (< 6 N	ptimal heart failure therapy for at weeks or planned < 6 months)	
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Physician's Address	stratification. I have examined the above release refer to Nutrition Serv	nes per week for up to anamed patient and see notices as indicated.	o contraindicatior	fications may occu		
	Physician's Name (Please Print) Signature o		Signature of Re	ferring Physician	Date	
Physician's Phone Number Physician's FAX Number	Physician's Address					
CARRIAC RELIABILITATION WITH MONITORING	Physician's Phone Number					



CARDIAC REHABILITATION WITH MONITORING PHASE II REFERRAL

