Cardiac Rehabilitation

Referral Form

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____
Address: _____ Phone: _____ Language: _____
City: _____ State: _____ Zip Code: _____

PHYSICIAN ADMISSION DATA

Referring Provider: _____ Date of Referral: _____
Phone Number: _____ Fax Number: _____
Physician Care Physician: _____ Phone Number: _____

INSURANCE DATA

Insurance Company: _____ Subscriber Name: _____
Is insurance authorization required? ☐ **Yes** ☐ **No** **Authorization #:** _____ Approved for date range of: _____
Policy Number: _____ Group Number: _____ Subscriber's Phone Number: _____

PHASE 2 TELEMETRY MEASURED PROGRAM

Frequency: _____ times per week for: _____ weeks. _____
Referring Physician (*please print*): _____ Phone: _____

PHYSICIAN SIGNATURE: (*I certify that the above services are required on an outpatient basis*)

X _____ _____
Must be signed by MD or DO (*No signature stamps please*) Date

Diagnosis/Reason for Cardiac Rehabilitation Therapy: Check all that apply.
(*ICD-10 codes are provided for your convenience/reference only. please change as appropriate.*)

☐ Acute myocardial infarction (*within preceding 12 months*)
Specify: Type of MI: Date of MI:
☐ Coronary artery bypass surgery (Z95.1)
Date of CABG:
☐ Coronary stenting (Z95.5)
Date of procedure:
☐ PTCA (Z98.61)
Date of procedure:
☐ Heart valve replacement: Please select one (Z95.2, Z95.3, Z95.4)
Specify: Type of valve: Date of procedure:
☐ Heart valve repair (Z48.812)
Date of procedure:

Heart failure: Specify EF and NYHA class below:
☐ Chronic systolic heart failure (I50.22)
☐ Chronic combined systolic and diastolic heart failure (I50.42)
☐ Ischemic cardiomyopathy (I25.5)
Ejection Fraction:
NYHA Classification:

Eligibility Criteria for Heart Failure:
Ejection Fraction of 35% or less and New York Heart Association (NYHA) Class II to IV symptoms despite being on optimal heart failure therapy for 6 weeks.

☐ Other diagnosis (specify): _____

Supporting documentation such as recent labs, chart notes, and medication list must accompany referral.

PHASE 3 MAINTENANCE PROGRAM (PLEASE SIGN ONE OF THE FOLLOWING)

Copy of Stress Test sent: _____ _____
Signature Date

Waive Stress Test: _____ _____
Signature Date

Thank you for your referral! After receiving this form we will contact the patient to set up the appointment. Your office will be notified if we are unable to make contact with the patient or the patient refuses services.

salemhealth.org

Cardiac Rehabilitation
665 Winter St. SE, Building B
Salem, OR 97301
Scheduling: 503-814-1700, Option 2
Fax complete form to: 503-561-1435

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