Cardiac Rehabilitation

Referral Form

Salem Hospital
A part of Salem Health

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: ______________________

Primary 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 ____ Date: __________

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

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 (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)

☐ Heart failure: Ejection Fraction: __________
NYHA Classification: _________

☐ Other diagnosis (specify): ______________
____
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____

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.

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

PHASE 3 MAINTENENCE PROGRAM (*Please sign* ***one*** *of the following):*

Copy of Stress Test sent: ______________________________ Date: __________
Signature

Waive Stress Test: ______________________________ Date: __________
Signature

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 **Fax complete form to: (503) 561-1435** **Scheduling: (503) 814-1700 option 2**

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