Conway Medical Center
Cardiac Rehabilitation Program

Outpatient Referral Order

2369 Cypress Circle
Conway, SC 29526
Phone: (843) 347-8153
Fax: (843) 347-1536 or (843) 234-8905

Patient Name: _____

Address: _____

_____

Phone: _____

Age: _____ Sex: _____ DOB: _____

Please check appropriate diagnosis and provide date of procedure:

____ MI Date: _____
____ CABG Date: _____
____ Valve Replaced Date: _____
____ Heart Transplant Date: _____
____ Stable Angina Date: _____
____ PCI with Stent Date: _____
____ Valve Repaired Date: _____
____ Other _____

Location of Procedure: _____

Heart Failure with NYHA Classification ____ (Classification II – IV eligible for Phase 2)

____ Chronic Systolic Heart Failure – 150.22
____ Chronic Diastolic Heart Failure – 150.32
____ Chronic Combined Heart Failure – 150.42

Please check the program appropriate for your patient:

____ Phase 2 (EKG monitoring CPT 93798 and non-monitoring CPT 93797)
3 visits per week up to 36 sessions
____ Phase 3 (Maintenance Self Pay; Intermittent EKG monitoring)

Pre-entry Stress Testing of patients is recommended by the South Carolina Cardiopulmonary Rehabilitation Association and required by Medicare. Please check your plan regarding a Stress Test for your patient.

____ Stress Test was performed post event and I will forward the results.
____ I will schedule my patient for a Stress Test prior to program entry.
____ I do not want my patient to have a Stress Test at this time for the following reason:
____ Recent MI ____ Recent CABG ____ Recent Cardiac Catheterization ____ Other

Please enroll my patient in the Cardiac Rehabilitation Program. As this patient's referring physician, I can expect regular reports regarding my patient's progress.

_____ _____ _____
Physician Signature Physician Name – Printed Date

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