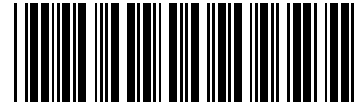
ST. JOSEPH'S HEALTH
Hospital
A Member of Trinity Health




# CARDIAC REHABILITATION PROGRAM
# REFERRAL FORM

Patient's Name: ________________________________ DOB: ______________________

Patient's Phone: ________________________________

☐ **CARDIAC REHABILITATION:** Monitored and/or supervised exercise, education and counseling for rehabilitation and secondary prevention.

**DIAGNOSIS / DATE:**

- ☐ MI ____________________
- ☐ CABG ____________________
- ☐ Stable Angina ____________________
- ☐ + Stress Test ____________________
- ☐ PTCA/Stent____________________
- ☐ Cardiomyopathy ____________________
- ☐ AVR/MVR ____________________
- ☐ Pacer/AICD implant ____________________
- ☐ Heart Transplant ____________________
- ☐ Other ____________________

Physician's Signature: ________________________ Date: ________________________

________________________________ Physician's Name (please print or stamp)

________________________________ Phone

**Please FAX to (315) 458-5715** St. Joseph's Cardiopulmonary Rehabilitation Program
For more information, please call (315) 458-7171