

**HEALTHY LIVING CENTER AT GREENWICH HOSPITAL**  
**CARDIAC REHABILITATION PROGRAM PHYSICIAN REFERRAL & ORDER FORM**  
**FAX # 203-863-3744      PHONE # 203-863-3756**

Patient's Name: \_\_\_\_\_

Patient's Phone # \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

**TELEMETRY MONITORED**

**CARDIAC SUPERVISED PROGRAM**

MI      *Date*      *Anatomical Location*  
                     \_\_\_/\_\_\_/\_\_\_      \_\_\_\_\_

Pacemaker      *Date*      Rate\_\_\_\_  
   \_\_\_/\_\_\_/\_\_\_

CABG      \_\_\_/\_\_\_/\_\_\_      \_\_\_\_\_

CHF      \_\_\_/\_\_\_/\_\_\_

Angina      \_\_\_/\_\_\_/\_\_\_      \_\_\_\_\_

HTN      \_\_\_\_\_ mm Hg

PTCA      \_\_\_/\_\_\_/\_\_\_      \_\_\_\_\_

Hyperlipidemia      *(Please send lipid levels)*

Valve Replacement/Repair      \_\_\_/\_\_\_/\_\_\_

Other \_\_\_\_\_

Heart/Heart Lung Transplant      \_\_\_/\_\_\_/\_\_\_

**\*\*Above Services Covered By Medicare**

**\*\*Above Services NOT Covered By Medicare**

• **MEDICATIONS:**

• **CONTRAINDICATIONS/LIMITATIONS TO EXERCISE:**

• **ALLERGIES:** \_\_\_\_\_

**\*\* STRESS TEST RESULTS:** *Please send a copy of results with 12 Lead EKG included*      Date \_\_\_\_\_

ST Changes \_\_\_\_\_      EF \_\_\_\_\_ %      Target Heart Rate \_\_\_\_\_ bpm

Arrhythmias/Symptoms \_\_\_\_\_

**\*\*Please send any pertinent information. I.e. Cath. Report, Surgery Report, Lipid Profile**

**REFERRING PHYSICIAN SIGNATURE** \_\_\_\_\_

**Physician Phone #** \_\_\_\_\_ **Physician Fax #** \_\_\_\_\_