Goshen Hospital

Cardiopulmonary Rehab Services
1855 South Main St., Suite B
Goshen, IN 46526
Office 574-364-2587 Fax 574-364-2531

Patient Name ___________________________	Ordering Physician Signature ______________________
Date of Birth ___________Social Security _________	Ordering Physician ____________________________
Address ________________________________	
City _______________State ______Zip _______	Primary Care Physician __________________________
Telephone # _____________________________	Send Copy To _________________________________
	Fax Results To ________________________________
Primary Insurance ___________________________	
Primary Policy # ______________Group # _______	Diagnosis #1 ____________ICD-10 Code __________
	Diagnosis #2 ____________ICD-10 Code __________
Secondary Insurance _________________________	Diagnosis #3 ____________ICD-10 Code __________
Secondary Policy # ____________Group # _______	Diagnosis #4 ____________ICD-10 Code __________

Cardiac Rehabilitation Referral Form

Date of referral: ________________________

Date of qualifying event: __________________

❑ Cardiac Rehab

For required safety and admission qualifications, I authorize the following:

- Rehab staff to develop Individualized Treatment Plan/Exercise Rx for Medical Director to review and approve on admission to the program and every 30 days until discharge from program
- 6 Minute Walk Test pre and post program
- Cardiopulmonary Stress Test pre-program (as indicated by HF stratification)
- 12 Lead EKG within 3 months of the qualifying event

❑ Intensive Cardiac Rehab *(Ornish Lifestyle Medicine)*

For required safety and admission qualifications, I authorize the Cardiac Rehab requirements listed above, in addition to:

- Labs pre program (if no draw in the past 3 months) and post program including lipids, HgbA1c and hsCRP
  - ✓ **Diagnosis #1 ___________ICD-10 Code ____________**
  - ✓ **Diagnosis #2 ___________ICD-10 Code ____________**

I hereby certify that the above patient is medically able to participate in Cardiac Rehab.

PLEASE FAX COMPLETED FORM TO
574-364-2531