METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

Heart & Vascular

Referral for Phase II Cardiac Rehabilitation

Patient information – Please fill out completely

Patient's Name (Last, First) _____

Patient's Date of Birth _____

Referral Information

Diagnosis / ICD:10

- ☐ Acute myocardial infarction (STEMI)
- ☐ Acute myocardial infarction (NSTEMI) (I21.4)
- ☐ Cardiac transplantation (Z 94.1)
- ☐ Cardiac valve surgery (or repair) (Z 95.2)
- ☐ Chronic heart failure (EF ≤ to 35%) (I50.22)
- ☐ Coronary angioplasty or stenting (Z 95.5)
- ☐ Coronary artery by-pass surgery (Z 95.1)
- ☐ Stable angina (I20.9)
- ☐ Other

I wish to refer this patient to Cardiac Rehabilitation Services and:

☐ I have seen and examined this patient, and believe he/she is ready to participate in Cardiac Rehabilitation.

☐ I believe this patient is surgically stable and able to begin rehab after review by _____

_____
Physician signature

_____
Physician name (print)

_____ _____
Time Date

10/20

Heart & Vascular
2122 Health Drive SW | Wyoming, MI 49519
p **616.252.4139** | f 616.252.7515 | metrohealth.net

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