LEXINGTON MEDICAL
Heart and Vascular Center

CARDIAC REHAB REFERRAL

PATIENT INFORMATION

Patient Name:_____ DOB:_____

Home/Cell Phone:_____ Work Phone:_____

Address:_____
Street City State Zip

PATIENT DIAGNOSIS (Check at least one)	DATE DIAGNOSED	ICD10
☐ MI		
☐ CABG X ____		
☐ PTCA/PCI/Stent		
☐ Stable Angina		
☐ AVR/MVR/TAVR		
☐ CHF* *Required for CHF: NYHA Class _____ (Class II-IV) | EF _____% (must be < 35%)		
☐ Other Diagnosis		

PREFERRED LOCATION
(Check one)

☐ **Cardiac Rehab - Main Campus**
2728 Sunset Boulevard
West Columbia, SC 29169
Ph: (803) 791-2621 | **Fx:** (803) 791-2568

☐ **Cardiac Rehab - Irmo**
7033 St. Andrews Road, Suite 103
Columbia, SC 29212
Ph: (803) 732-5388 | **Fx:** (803) 936-7851

☐ **Cardiac Rehab - Lexington**
811 West Main Street, Suite 212
Lexington, SC 29072
Ph: (803) 358-6180 | **Fx:** (803) 358-6187

REQUESTED CARDIAC REHAB SERVICE (Check one)	CRITERIA
☐ **Phase II** **Duration:** Up to 36 visits | **Frequency:** 3 days/week (12 weeks) **If selected, can continue into Phase III**	Within 12 months of cardiac event: MI, CABG, Stable Angina, PCI, CHF, Post-heart transplant, Valve replacement
☐ **Phase III** **Duration:** Up to 3 months | **Frequency:** 2-3 days/week	Does not meet Phase II criteria, but with disease or cardiovascular risk

REFERRING PROVIDER INFORMATION

Practice Name:_____

Address:_____
Street City State Zip

Phone:_____ Fax:_____

Referring Physician

Printed Name: _____ NPI:_____

Signature: _____ Date:_____