GIRARD Medical Center
Outpatient Cardiac Rehab
Phone: 620-724-5126
Fax: 620-724-5127

Patient Information: **Date:**

Patient Name: _____ Date of Birth: _____

Address: _____

(City) (State) (Zip Code)

Phone: _____

Patient SS#:_____ Sex: M F

Diagnosis:

Post MI – within last year

- ☐ - 121.01 STEMI L main coronary artery
- ☐ - 121.02 artery L anterior descending coronary artery
- ☐ - 121.09 other coronary artery – anterior wall
- ☐ - 121.11 R coronary artery
- ☐ - 121.19 other coronary artery – inferior wall
- ☐ - 121.21 L circumflex coronary artery
- ☐ - 121.29 other sites
- ☐ - 121.3 unspecified sites

Post CABG

- ☐ - 125.5 Ischemic cardiomyopathy
- ☐ - 125.708 Atherosclerosis of CABG- unspecified, w/ other angina pectoris
- ☐ - 125.709 Atherosclerosis of CABG- unspecified, w/ unspecified angina pectoris
- ☐ - 125.810 Atherosclerosis of CABG- w/o angina pectoris
- ☐ - 125.811 Atherosclerosis of native coronary artery transplanted heart- w/o angina pectoris
- ☐ - 125.812 Atherosclerosis of bypass graft of transplanted heart- w/o angina pectoris
- ☐ - 125.89 Other forms of chronic ischemic heart disease
- ☐ - 125.9 Chronic ischemic heart disease, unspecified

Stable Angina Pectoris

- ☐ - 120.1 Prinzmetal Angina Pectoris
- ☐ -120.8 Other forms of Angina Pectoris
- ☐ - 120.9 Angina Pectoris - unspecified

Post Heart Valve Transplant

- ☐ - Z94.1 Heart transplant status
- ☐ - Z94.3 Heart and lungs transplant status

Post Valve Repair or Replacement

- ☐ - Z95.1 Aortocoronary bypass graft
- ☐ - Z95.4 Presence of other heart-valve replacement

Post PTCA and/or PTCA/Stent

- ☐ - Z95.5 Coronary angioplasty implant graft
- ☐ - Z98.61 Coronary angioplasty status

Secondary Diagnosis:

☐ Hypertension ☐ Hyperlipidemia ☐ Obesity ☐ Diabetes ☐ Congestive Heart Failure

Social History:

Tobacco: ☐ Current ☐ Quit ☐ Never Packs per day:_____

Type: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Smokeless Tobacco

Physician Referral:

☐ **I have examined the patient listed above and determined that his/her admission into the Cardiac Rehabilitation Program is medically necessary.**

Physician's Name (please print):_____

Physician's Signature:_____ Date:_____ Time:_____

Office Phone#: _____ Office Fax#:_____

Please fax copy of cardiac stress test results, labs, medical history, face sheet, last progress note, and medication list to 620-724-5127.