DeKalb Medical
Tax ID Number 58-1966795

PS-1050

Cardiac Rehabilitation Order Form
FAX orders to: 404.501.7689
Phone: 404.501.7155

Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: ❑ M ❑ F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Order Information - Cardiac Rehabilitation

❑ **Outpatient Cardiac Rehabilitation – Phase II** (CPT 93798)

Diagnosis (please check all that apply):

Note: Medicare will ONLY cover the following diagnoses.

❑ MI
❑ CAD
❑ PTCA
❑ CABG
❑ Stable Angina
❑ Heart Transplant
❑ Valve Repair/Replacement
❑ CHF (EF≤35%)

❑ Other (please specify): _____

ICD-CM Codes for Selected Diagnosis and Other: _____

Please include the following information with this referral:

❑ Medical History/Physical and/or Discharge Summary
❑ Stress Test Results (if available)
❑ Resting 12-Lead ECG (most recent, if available)
❑ Lipid Profile Results (if available)
❑ CABG or PTCA Report
❑ Current Medication List

The above patient may participate in **Outpatient Cardiac Rehabilitation** consisting of EKG monitored exercise and personal risk modification instruction.

❑ **Patient may participate in outpatient Cardiac Rehabilitation following stress test.**
Stress test results are included with this referral.

❑ **Patient may participate in outpatient Cardiac Rehabilitation without stress test.**
Exercise to a heart rate of resting plus 20 beats/minute (or Target Heart Rate of 60-85%) and/or rate of perceived exertion of 11-14 on Borg scale (6-20).

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License #: _____

Physician Address: _____ Phone #: _____ Fax #: _____

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ **Date:** _____ **Time:** _____