

## Cardiac Rehab Referral – Letter of Medical Necessity

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Phones – Home: \_\_\_\_\_ Work/Cell: \_\_\_\_\_

I am referring my patient to ☐ **Phase II** or ☐ **Phase III** of the Cardiac Rehab program. I feel that this rehabilitation program is medically necessary for my patient to be assessed and treated due to the patient's history and following diagnosis:

My patient will receive an entry stress test, an individual nutritional consultation, 3-12 weeks of telemetry monitoring, an individualized progressive exercise program, weekly education classes, and an exit stress test.

### Diagnosis:

- |                                                           |             |
|-----------------------------------------------------------|-------------|
| <input type="checkbox"/> Stable Angina                    | Date: _____ |
| <input type="checkbox"/> Acute Myocardial Infarction      | Date: _____ |
| <input type="checkbox"/> Coronary Artery Bypass Surgery   | Date: _____ |
| <input type="checkbox"/> PTCA or Coronary Stent           | Date: _____ |
| <input type="checkbox"/> Heart Valve Repair / Replacement | Date: _____ |
| <input type="checkbox"/> Heart or Heart-Lung Transplant   | Date: _____ |
| <input type="checkbox"/> Heart Failure (HF)               | Date: _____ |
| <input type="checkbox"/> Other: _____                     |             |

- HF patients must be stable meaning no recent ( $\leq 6$  wks) hospitalizations or planned ( $\leq$  months) major cardiovascular hospitalizations or procedures.
- HF patients must have  $\leq 35\%$  left ventricular ejection fraction.
- HF patients must have New York Heart Association class of II-IV.

### Required Documents – Please attach

- ☐ 12 Lead EKG (Resting)
- ☐ Stress Test (Date): \_\_\_\_\_ or check below
  - ☐ Stress Test will be scheduled in physician's office and copy sent to Cardiac Rehab.
  - ☐ Stress Test will be scheduled in Cardiology at NGMC.
- ☐ Lipid Profile or check below
  - ☐ Lipid Profile will be done in physician's office and copy sent to Cardiac Rehab.
  - ☐ Lipid Profile may be done at NGMC.
- ☐ EF (if known)
- ☐ Hemoglobin A1C (Diabetes)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Please return to:

- |                                                             |                     |                   |
|-------------------------------------------------------------|---------------------|-------------------|
| <input type="checkbox"/> Northeast Georgia M.C. Gainesville | Phone: 770-219-8290 | Fax: 770-219-8262 |
| <input type="checkbox"/> Northeast Georgia M.C. Braselton   | Phone: 770-848-7190 | Fax: 770-219-3317 |
| <input type="checkbox"/> Habersham Medical Center           | Phone: 706-754-3113 | Fax: 706-754-8908 |
| <input type="checkbox"/> Stephens County Hospital           | Phone: 706-282-4182 | Fax: 706-282-4184 |

### RECOMMENDED START TIMES FOR CARDIAC REHAB

Uncomplicated MI ..... 2 Weeks Post Event  
CABG ..... 2 Weeks Post Surgery

PTCA ..... 1 Week Post PTCA  
Angina ..... When Stable



Northeast Georgia Medical Center

**CARDIAC REHAB REFERRAL –  
Letter of Medical Necessity**



456-02203

NGMC FORM # 456-02203 (1/27/22)

PATIENT IDENTIFICATION: