Wilkes Medical Center
1370 West D Street.
North Wilkesboro, NC 28659
Phone: (336) 903-6980 Fax: (336) 903-6981 or (336) 651-8761

Cardiac Rehabilitation Program Physician Order Form to Consult and Treat

Patient's Name:	**DOB:**	**MR#:**

Diagnosis: (Please check all that apply)

- ☐ NSTEMI I21.4
- ☐ STEMI
  - left main I21.01
  - LAD I21.02
  - RCA I21.11
  - LCx I21.21
  - Other anterior I21.02
  - Other inferior I21.19
  - Other I21.29
  - Unspecified I21.3
- ☐ Stent/ Angioplasty Z98.61
- ☐ CABG Z95.1
- ☐ Valve replacement z95.3

- ☐ CHF NYHA Class ____ EF ____
  Clinically stable on optimized medical treatment
  - Systolic HF I50.22
  - Diastolic HF I50.32
  - Unspecified I50.9
- ☐ Angina I20.9
- ☐ Heart Transplant Z94.1
- ☐ Other (valve repair, valvuloplasty, aortic aneurysm repair, aortic root repair/replacement) Z98.89
- ☐ Other:_____
  (Diagnoses other than listed above will not be covered by Medicare)

Date of Diagnosis (if known) :

Disease Related Complications/Exercise Limitations:

Cardiac Rehab Exercise Protocol:

- ☐ Frequency: 36 sessions
  Date range of referral _____
- ☐ Duration: 31-60 minutes per session
- ☐ Type: aerobic exercise to include track walking, treadmill, bicycle, nustep, elliptical machine, and/or arm ergometer
- ☐ Intensity: 40-85% of peak heart rate reserve
- ☐ RPE: 11-14 (Borg 6-20 Scale)

Please indicate any individual changes needed to be made to exercise prescription:

I have examined the above patient and have found him/her medically qualified to participate in the above ordered activities.

_____ _____
Physician Name (Please Print) Note: Must be a MD/DO **Physician Contact Number**

_____ _____
Physician Signature **Date/Time Signed**