Cardiac Rehab Referral/Prescription Form

United Regional Health Care System
Cardiopulmonary Rehabilitation
(940) 764-8284 Phone 1600 Eleventh St. Wichita Falls, TX 76301

Please provide the following information:		
Patient Name:	**Date:**	**Time:**
Phone Number:	**DOB:**	
Referring Physician:		
Diagnosis:		

If Heart Failure diagnosis, please document NYHA Class_____ and EF_____

(Please list any limitations you request for this patient):

_____

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***Medicare only covers cardiac rehab for the following diagnosis:**

Stable Angina (120-120.9)
Myocardial Infarction (within last year) (125.2)
Coronary Artery Bypass Surgery (within last year) (Z95.1)
Heart Valve Repair or Replacement (within last year) (Z95.2)
PTCA or coronary stenting (within last year) (Z95.5)
Heart or combined Heart-Lung transplant (Z94.1/ Z94.3)
Stable Chronic Heart Failure (150.9)

Defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to class III symptoms despite being on optimal heart failure therapy for at least six weeks. Stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures.

MD Signature_____

PLEASE SIGN AND FAX TO (940) 764-8289

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