UNIVERSITY of MARYLAND
UPPER CHESAPEAKE MEDICAL CENTER
MEMBER OF UPPER CHESAPEAKE HEALTH

Cardiac Rehabilitation Exercise Referral Form

PARTICIPANT NAME: _____ DOB:_____ DATE: _____
PARTICIPANT PHONE NUMBER: (H) _____ (W) _____
PHYSICIAN: _____ PHYSICIAN'S PHONE #: _____

REFERRAL TO: PHASE II (Telemetry-monitored exercise sessions **CPT code: 93798**) for 36 sessions
TO BE COMPLETED BY PHYSICIAN: **Fax to: 443-643-3731**

1. **Please check the appropriate diagnosis. Please indicate all that apply.**

ICD-10 Code and Specific Date (00/00/0000) *must* be included with diagnosis

Primary:	ICD-10 Code	Date
❑ MI >56 days	I25.2	___/___/____
❑ STEMI	I21.XX	___/___/____
❑ NSTEMI	I21.4	___/___/____
❑ CABG	Z95.1	___/___/____
❑ Stable angina	I20.9	___/___/____
❑ PTCA/stent	Z95.5	___/___/____
❑ Valve repair/replacement	Z95.2 (prosthetic)	___/___/____
❑ Valve repair/replacement	Z95.3 (porcine)	___/___/____
❑ Heart transplant	Z94.1	___/___/____
❑ CHF	I50.9	___/___/____
❑ *Specify Other:* *(e.g.- Cardiomyopathy)*	**ICD-10 Code**	**Date**
_____	_____	___/___/____
❑		

Obtain 12-lead EKG for any NEW onset:

☑ Arrhythmia (sinus, supraventricular, ventricular)	I49.9	☑ Angina	I20.9
☑ Block	I45.9	☑ Ectopy	I49.8
☑ Subacute ischemia	I24.8	☑ Other: _____	

_____ _____
Authorized Provider Signature **Date**

Form # 65784 4/16 Pink – Medical Record White – Cardiac Rehab Yellow - Patient