



CEDARS-SINAI MEDICAL CENTER.

PREVENTATIVE AND REHABILITATIVE CARDIAC CENTER

PRCC • 8631 W. THIRD STREET • SUITE 740E • LOS ANGELES • CA 90048 • PHONE 310-423-9660 • FAX 310-423-9668

REFERRAL FOR CSMC CARDIAC REHABILITATION

PLEASE FAX THIS FORM BACK TO US AT 310-423-9668

TIME: _____ DATE: _____

Patient name: _____ DOB: _____ CSMC# (If applicable) _____

Referred to CR: Monitored Unmonitored program

Diagnosis:	Date Diagnosed:
<input type="checkbox"/> CAD	_____
<input type="checkbox"/> Angina: Stable or other: _____	_____
<input type="checkbox"/> S/P PTCA or PTCA w/stent	_____
<input type="checkbox"/> S/P CABG	_____
<input type="checkbox"/> S/P Aortic / Mitral / Tricuspid - Valve Repair	_____
<input type="checkbox"/> S/P Aortic / Mitral - Valve Replace (<i>mechanical</i>)	_____
<input type="checkbox"/> S/P Aortic / Mitral - Valve Replace (<i>tissue</i>)	_____
<input type="checkbox"/> S/P Heart Transplant	_____
<input type="checkbox"/> S/P Myocardial Infarction	_____
<input type="checkbox"/> S/P Other _____	_____

For those patients NOT hospitalized @ CSMC with the above diagnosis, we are REQUIRED to have the following information for their charts:

- H&P
- Lipid Panel
- D/C summary
- TMST
- 12 lead EKG

REQUIRED:

MD Printed Name		CSMC ID #		NPI #	
Signature / Title			Date		Time
Comments:					