



Physician Order Form for Cardiac Rehab

Patient Name: _____ DOB: _____

- Cardiac Rehabilitation** (36 sessions)
ECG monitored and supervised exercise for cardiac, at-risk cardiac, and Heart Failure patients. 36 sessions. Typical program is 1-2 hours per day, 1-2 days per week, for up to 36 weeks.
- Intensive Cardiac Rehabilitation** (72 sessions)
ECG monitored and supervised exercise and education for cardiac and post cardiac surgery patients. Typical program is 2 hours per day, 3 days per week, for 12 weeks.

BRIEF MEDICAL HISTORY (check all that apply):

- Stable Angina Pectoris
- Bypass Surgery (CABG)
- PCI/Stent
- Myocardial Infarction (circle one) STEMI / NSTEMI Date: _____
- Heart / Lung Transplant (circle one)
- Valve Surgery (circle one) Transplanted Tissue / Prosthetic / Other valve replacement
- Other: _____
- Chronic Systolic Heart Failure
CHF Qualifying Criteria (Please complete ALL criteria fields)
 - LVEF = _____ *must be < 35% to qualify
 - Stable Chronic Heart Failure i.e. No recent (< 6 weeks) or planned (< 6 months) major cardiovascular hospitalization or procedure:
 - Yes Date of hospitalization/procedure: _____
 - No

Goals, restrictions or additional comments: _____

This patient is medically stable and cleared to begin cardiac rehabilitation.

Physician Signature: _____ Date/Time: _____

Physician Printed Name: _____ Phone Number: _____

Please fax this form with accompanying documents to 501-687-6880

If patient is not an Arkansas Heart Hospital Clinic patient, please send the patient's facesheet, along with the most recent ECG, stress test, and clinic note. If a recent stress test has not been performed, one may be required before we can schedule an evaluation for the program.