Cardiac Rehabilitation Program
Physician Referral

Patient Name: _____ Date of Birth: _____Phone: _____

Insurance: _____

Monitored exercise and education program with assessment, interventions and goals setting to reduce further risk of coronary event and improve quality of life.
Referred to Location:

- ☐ **Tacoma General Hospital**
  - Please fax this form to (253) 403-4386
- ☐ **Gig Harbor Medical Park**
  - Please fax this form to (253) 403-4386
- ☐ **Good Samaritan Hospital – Medical Office Building**
  - Please fax this form to (253) 697-3325
- ☐ **Auburn Medical Center**
  - Please fax this form to (253) 333-2607
- ☐ **Capital Medical Center**
  - Please fax this form to (360) 956-1930
- ☐ **Deaconess Hospital**
  - Please fax this form to (509) 473-2039
- ☐ **Valley Hospital**
  - Please fax this form to (509) 473-2039

Diagnosis

The following are usually covered by most insurance. Please check all that apply:
Please send supporting documentation of diagnosis selected.

	Date of Onset
☐ NSTEMI/STEMI (within preceding 12 months)	_____
☐ Coronary Artery Bypass Graft	_____
☐ PCI	_____
☐ Stable Angina Pectoris	_____
☐ Valve Repair/Valve Replacement/TAVR	_____
☐ LVAD	_____
☐ Heart Failure-qualifying requirements: EF ≤ 35%	_____
☐ Heart Transplant	_____

Physician's Name: _____

Physician's Signature: _____ Date: _____