Home Rehabilitation Network

Fax to: 410-871-4022

Telemedicine Cardiac Rehabilitation Program

REFERRAL FORM

PARTICIPANT NAME: _____ DOB: _____

PHONE: _____

EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

TO BE COMPLETED BY PHYSICIAN

1. **ICD-10 Code MUST be included with diagnosis (Please check the appropriate box)**

☐ Admit to Cardiac Rehab Program – 36 sessions

Diagnosis	ICD-10 Code
☐ CHF	I50.9
☐ 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
☐ MI > 56 days	I25.2
☐ Other Heart Disease/Surgery	_____

**** PLEASE SEND A COPY OF THE MOST RECENT OFFICE NOTE WITH YOUR REFERRAL**

2. **Obtain 12-lead EKG for any NEW onset:**

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

Physician Signature: _____

Please print name: _____

PHONE #: _____

FAX #: _____