

Outpatient Cardiac Rehabilitation and Secondary Prevention Program Prescription Form

Dear Dr. _____

We feel this patient would benefit from an Outpatient Cardiac Rehabilitation and Secondary Prevention Program due to the following diagnosis and modifiable risk factors present.

American Heart Association Indications for Referral:

- MI* Stable Angina* CABG* PTCA/Stent*
 CHF OHT* Valvular Surgery*

* Indicates Medicare Covered Diagnosis

Modifiable/Controllable Risk Factors:

- Smoking Hypertension Diabetes Hypercholesterolemia
 Body Weight High Stress Levels Sedentary Lifestyle

Please sign the order below if you feel this is appropriate and the nurse will give a copy to your patient.

Thank you, _____

Name _____ Age _____

Address _____ Date _____

Begin Outpatient Cardiac Rehabilitation and Secondary Prevention Program

Diagnosis: _____

Monitored exercise 3 X per week, X _____ weeks

Risk factor reduction education

Progress according to Seton Cardiac Rehab Protocol

Progress to _____ METs. _____ minutes of exercise per session.

_____ M.D. _____ M.D.

Product selection permitted

Dispense as written

DEA # _____