

**CARDIAC REHABILITATION
PRESCRIPTION FOR SERVICES**

1100 S. Van Dyke Road, Bad Axe, MI 48413 - Phone (989) 269-1611 Fax (810) 600-7119

Name: _____ Primary Physician: _____
DOB: _____ DOS: _____ Cardiologist: _____
Other: _____

Primary Diagnosis (must check one):

- CAD
- Valve Disorder (specific valve): _____ or Unspecified
- Stable, Chronic Heart Failure EF _____% NYHA Classification _____

Secondary Diagnosis (check if applicable):

- PTCA with or without stenting MI
- CABG Current (4wks or 28 days)
- Valve Repair - Aortic Mitral Other _____ Old (>28 days post MI)
- Valve Replacement - Aortic Mitral Other _____
- Stable Angina
- Heart Transplant
- Other _____

PRESCRIBED PLAN OF CARE

- PHASE II** - Telemetry monitored exercise 3 times weekly up to 36 sessions paired with risk factor modification classes.
 - Workloads adjusted to accommodate for blood pressure, heart rate, rate of perceived exertion and symptoms. Target heart rate to equal Resting Heart Rate +20 - +50 unless otherwise specified.Additional Instructions: _____
- PHASE III** - Supervised exercise classes 2-3 times weekly, as patient desires, paired with risk factor modification classes.
 - Supervised exercise in which patient has been educated on safe exercise practices and is able to adjust own workloads based on rate of perceived exertion and symptoms. Target heart rate to equal Resting Heart Rate +20 - +50 unless otherwise specified.Additional Instructions: _____
- PHASE II / PHASE III** - Based on the above protocols.

Physician Signature: _____ Date: _____ Time: _____

Print Name: _____

ADDRESSOGRAPH

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