

1PO

CardioDirect Phase 3 Physician Referral Form



(Referring Physician: first & last name)

Date _____

This patient, _____, DOB _____,
phone _____, desires to participate in the **CardioDirect or
Phase 3 Cardiac Rehabilitation Program (non-EKG Telemetry monitored)** at
DLP Twin County Regional Hospital.

- **History of:** **mo/day/year**

CABG	_____
MI	_____
PTCA/Stent	_____
Stable Angina	_____
Valve Surgery	_____
CHF	_____
Other	_____

- **Initiate DLP/TCRH Outpatient monitored exercise program following approved policies and procedures at 2-3 sessions per week. This patient may participate as long as needed or desired. Notify MD for any problems.**
- **Initiate teaching/counseling sessions as the patient's needs indicate.**
- **Patient may bring/use personal nitroglycerin tablets PRN chest pain (if applicable).**
- **Patient may use own personal inhaler PRN wheezing (if applicable).**
- **Patient may bring own glucometer to sessions and use as needed (if applicable).**
- **Additional orders:** _____

Physician Signature _____ **Date** _____

Patient release: I hereby authorize the above named physician or office to release all information requested and any other relevant information to the DLP/TCRH Cardiac Rehab program, and for the program to send any relevant information to any of my medical care providers.

Patient Signature Date Staff Requesting Referral

Please Fax to **276-238-2520** or mail to Cardiac Rehab Dept., DLP Twin County Regional Hospital, 200 Hospital Drive, Galax, VA 24333. Please call 276-236-1763 with any questions.