CARDIAC REHABILITATION PROGRAM - PHYSICIAN REFERRAL

① Patient Name (print):____ DOB: ______________________

Patient Telephone Number: ____

② Diagnosis: ____

ICD-10 Code: ____

③ SPECIAL INSTRUCTIONS or LIMITATIONS:

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④ **Referring Health Care Provider:** I consent to allow this patient to enroll into the Cardiac Rehabilitation Phase II Program and participate in the supervised and monitored exercise classes.

Referring Physician Name (print): ____

Referring Physician Signature: _____________________________________ Time: __________ Date: _________

Name of Office Contact: ____

Office Phone # __________________________________ Office Fax # _________________________________

⑤ Please fax referral and recent clinic notes to:

Cardiac & Pulmonary Rehabilitation Services at 425.899.3778

Call 425.899.3770 for information about our Cardiac Rehabilitation Program
12039 NE 128th Street, Suite 200, MS #3 | Kirkland, WA 98034