



Beaufort Memorial HOSPITAL

Out Patient Cardiac Rehab Physician Order

Patient Information		Pt Acct #:
Patient Name (Last, First, MI)		
Address:		
DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Patient SS#

Referral For: Cardiac Rehab Phase II

Diagnosis: MI (410.91) CABG (V45.81) PTCA/STENT (V45.82)

Valve Replacement (V43.3) Stable Angina (413.9) Other _____

Medical History: _____

Has this patient had:	YES	NO
History & Physical	<input type="checkbox"/>	<input type="checkbox"/>
Recent Office Visit	<input type="checkbox"/>	<input type="checkbox"/>
EKG	<input type="checkbox"/>	<input type="checkbox"/>
Surgery Reports	<input type="checkbox"/>	<input type="checkbox"/>
**Lipid Profile	<input type="checkbox"/>	<input type="checkbox"/>
Blood Sugar (Glucose)	<input type="checkbox"/>	<input type="checkbox"/>
PFT	<input type="checkbox"/>	<input type="checkbox"/>

**NOTE: Please send
copies of these reports
if available.**

****Lipid profile of six or more weeks. If not available, I authorize that necessary labs be obtained at Beaufort Memorial Hospital.** YES NO

SPECIAL INSTRUCTIONS: _____

Physician's Signature: _____

Date/ Time: _____



* 3 1 0 2 *