Goshen Hospital

Cardiopulmonary Rehab Services
1855 South Main St., Suite B
Goshen, IN 46526
Office 574-364-2587 Fax 574-364-2531

Patient Name _____	Ordering Physician Signature _____
Date of Birth _____Social Security _____	Ordering Physician _____
Address _____	
City _____State _____Zip _____	Primary Care Physician _____
Telephone # _____	Send Copy To _____
	Fax Results To _____
Primary Insurance _____	
Primary Policy # _____Group # _____	Diagnosis #1 _____ICD-10 Code _____
	Diagnosis #2 _____ICD-10 Code _____
Secondary Insurance _____	Diagnosis #3 _____ICD-10 Code _____
Secondary Policy # _____Group # _____	Diagnosis #4 _____ICD-10 Code _____

Cardiac Rehabilitation Referral Form

Date of referral: _____

Date of qualifying event: _____

❑ Cardiac Rehab

For required safety and admission qualifications, I authorize the following:

- Rehab staff to develop Individualized Treatment Plan/Exercise Rx for Medical Director to review and approve on admission to the program and every 30 days until discharge from program
- 6 Minute Walk Test pre and post program
- Cardiopulmonary Stress Test pre-program (as indicated by HF stratification)
- 12 Lead EKG within 3 months of the qualifying event

I hereby certify that the above patient is medically able to participate in Cardiac Rehab.

PLEASE FAX COMPLETED FORM TO
574-364-2531