

**Cardiac Therapy Foundation of the Midpeninsula
Rehabilitation and Wellness Center
Physician's Referral Form**

Patient's Name: _____

Phone number: _____

My patient **currently does not have:** unstable angina, uncompensated CHF, unexplained syncope, uncontrolled or symptomatic arrhythmias.

- I agree to have my patient participate in the Cardiac Therapy Program and in the event of a medical emergency, to be treated per ACLS protocols by ACLS certified personnel.
- I agree to have my patient counseled in measures designed to reduce coronary risk factors.
- I agree to continue the regular care of my patient throughout his/her participation in Cardiac Therapy.
- **If no stress test done post event, please indicate exercise parameters:**
 - () May exercise up to a heart rate of _____ and/or
 - () RPE of 13 (somewhat hard) if asymptomatic.
 - () Patient must wait for stress test to start program.
 - () Other instructions _____

Signature: _____ **M.D.**

Printed: _____ **Date** _____

I will fax or mail available records: _____ **OR**

Cardiac Therapy to obtain records _____

Hospital discharge summary following MI / unstable Angina / CABG / PTCA / heart failure

Patient's most recent ECG

Treadmill test.

Most recent lipid profile

Last office visit notes with medication list / diagnosis list.

Please send or fax to:

**Cardiac Therapy Foundation
4000 Middlefield Road, Suite G-8
Palo Alto, CA 94303
650-494-1300
Fax: 650-494-1301**

Standard services included: Supervised exercise training, including strength, flexibility, and aerobic conditioning / Weight loss – nutritional counseling / Blood sugar Management / Blood pressure monitoring / Cholesterol management/education - Nutritional Counseling / Heart Forum educational classes / Stress management.
Additional services (additional fee): Type A modification program.