GRIFFIN HEALTH

GRIFFIN HOSPITAL CARDIAC REHABILITATION PHASE 2 REFERRAL AND PLAN OF CARE

Patient Name: _____DOB: _____Today's Date: _____

Diagnosis/Procedure with Date:

Myocardial Infarction/**Date:** _____ Coronary Artery Bypass Graft/**Date:** _____
PCI w/or w/out Stent/**Date:** _____ Heart Valve Repair or Replace/**Date:** _____
Stable Angina Pectoris/**Date:** _____ Heart Transplant/**Date:** _____
Systolic Heart Failure NYHA Class II, III,IV w/EF <35%/**Date:** _____

Exercise Prescription: (Check One):
Intensity:
____ Follow Exercise Prescription of RN or Exercise Physiologist

OR
____ 40-85% of Age Predicted HR
____ _____BPM above RHR
___ *POST EVENT* GXT (65-85% of HR reserve)
____ Borg RPE of "10-13"
Frequency: 2-3 times per week
Mode: Continuous or intermittent aerobic exercise as tolerated
Strength Training: Increase resistance exercises as tolerated
Surveillance: Continuous ECG telemetry monitoring during exercise; daily weights, SpO2, lung assessments for patients with CHF.

Emergency Orders will be implemented if needed:
Notification of Referring MD for any deterioration in patient's clinical status.
Stat 12-lead ECG for unrelieved chest pain or changed or dysrhythmic ECG.
Administration of SL Nitro 0.4 mg as outlined in department Emergency Plan.
Administration of Aspirin 324 mg as outlined in department Emergency Plan.
Rapid Response/911 Call as outlined in department Emergency Plan.

Physician Signature: _____ Date/Time: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

PLEASE FAX THIS COMPLETED FORM W/CURRENT OFFICE NOTE, DC SUMMARY 12-LEAD ECG, PERTINENT LABS, GXT REPORT (IF AVAILABLE) AND FAX TO 203-732-1418. Call 203-732-7106 with questions.