

MEMORIALCARE®
ORANGE COAST MEDICAL CENTER
Heart & Vascular Institute

CARDIAC REHABILITATION
OCMMC
18111 Brookhurst, Suite 2450
Fountain Valley, CA 92708
Phone: 714-378-7260
Fax: 714-378-7661

Patient Name: _____

Patient Phone: (____) _____ **DOB:** _____

- Diagnosis:**
- Acute Myocardial Infarction (AMI)
Documented in preceding 12 months
 - Coronary Artery Bypass graft (CABG)
 - Heart or Heart/Lung Transplant
 - Percutaneous Transluminal Coronary Angioplasty (PTCA)
 - Coronary Stent
 - Stable Angina Pectoris
 - Valve Replacement (Aortic, Mitral) TAVR
 - Congestive Heart Failure (CHF)

Date of Initial Diagnosis: (Month/Day/Year) _____

- Procedure:**
- Cardiac Rehabilitation (CPT 93798). For 36 (1) hour sessions.
 - Cardiac Rehabilitation (CPT 99205). Initial Patient Evaluation.
- Target Heart Rate: _____
Metabolic Equivalent Table (MET) Level: _____

Physician Name: _____

Physician Signature: _____

Physician Office Phone: (____) _____ **Date:** _____