STURDY MEMORIAL HOSPITAL

CARDIAC REHABILITATION REFERRAL

Sturdy Memorial Hospital
211 Park St.
Attleboro, MA 02703
Phone: 508-236-7390
Fax: 508-236-7393
bastin@sturdymemorial.org

Dear Dr. _____ Date: _____

Our review indicates that your patient:_____ DOB: _____may be a candidate for Outpatient Cardiac Rehab at *Sturdy Memorial Hospital* with a diagnosis of _____**.**

If you would like to **refer** your patient please **sign below, indicate a diagnosis** and refax to us.

If your patient requires a stress test prior to coming to Cardiac Rehab please fax a copy of the stress test or let us know the date the patient will be having his/her stress test.

_____ Date: _____
MD Signature

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Date of Diagnosis ____/____/____

- ☐ NSTEMI
- ☐ STEMI – circle associated information if known
  Wall effected: Anterior, Inferior, Lateral, Posterior, Septal
  Vessels affected: RCA, LCA, LCX, LAD
- ☐ S/P Stents: Circle number of sites: 1, 2, 3, 4 or more
- ☐ Stable Angina
- ☐ Chronic CHF : pt qualifies with EF ≤35% , at least 6 weeks of therapy and **NYHA Class II III or IV** symptoms
  (please circle patient's class)
- ☐ CABG
- ☐ Valve Repair/Replacement
- ☐ Heart Transplant

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