Iberia MEDICAL CENTER

North Campus
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New Iberia, LA 70563

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IMC Cardio-Pulmonary Rehabilitation Physician Referral Form

Patient Name: _____ DOB: _____ Phone: _____

Diagnosis Criteria for Phase II Cardiac Rehab: Onset Date: _____

O CABG
O Myocardial Infarction
O PTCA w/Stent
O Stable Angina
O CHF < 35% EF
O Valve Replacement/Repair
O Heart Transplant

Diagnosis Criteria for Pulmonary Rehab or Respiratory Therapeutic Procedure Onset Date: _____

O Asthma
O Chronic Bronchitis
O Emphysema
O Other:_____
O Restrictive Lung Disease
O Chronic Respiratory Failure
O COVID Complications

Diagnosis Criteria for PAD Therapy: Onset Date: _____

O Peripheral Artery Disease Affected Limbs:_____

O *Enroll in Wellness Program based on risk factors* *Ex. HTN, Diabetes, ↑Chol., etc.*

If available, please provide the following documents:
◘ Recent Lab work
◘ 12 Lead EKG
◘ Recent Echo
◘ History and Physical
◘ Operation Report
◘ Miscellaneous Information

Patients referred to IMC Cardio-Pulmonary Rehab will be assessed and treated by staff members according to diagnosis, medical history, and current fitness level.
This is base upon:
1. Frequency- 3-5 days a week
2. Duration- 30-60 minutes
3. Intensity- Diagnosis based THRR, RPE, METS, etc.
4. Mode- Treadmill, Bike, Recumbent Machines, Rower, etc.
5. Progression- Generally 5-10% increase every 2-3 weeks

Specific Orders: _____

- **Thank you for referring your patient's care to IMC Cardio-Pulmonary Rehab**

Physician Signature: _____ Date: _____