# The Joan and Joel Smilow Cardiac Rehabilitation and Prevention Center

**FAX to (646) 754-9652**

***REFERRAL FOR OUTPATIENT CARDIAC REHAB***

Date: _____

Patient Name: _____ Sex (Please Circle): F M

Patient Date of Birth: _____ Patient Social Security Number: _____

Telephone Number: Contact 1: (_____)_____-_____

Contact 2: (_____)_____-_____

Patient Address: _____

_____

Primary Insurance: _____ Policy Number: _____ Insured Name: _____

Secondary Insurance: _____ Policy Number: _____ Insured Name: _____

***Indication for Cardiac Rehabilitation (please select ALL that apply)***

| ***Cardiovascular Diagnosis*** | ***Onset Date(s)*** | ***Treating Institution*** |
|---|---|---|
| _____ Myocardial Infarction (within 1 year) | _____ | _____ |
| _____ Coronary Artery Bypass Surgery (within 6 months) | | |