Mountain View Hospital

Cardiac, Peripheral Artery Disease and Pulmonary Rehab

Telephone 208-542-7174 Fax 208-525-4906

Patient Information

Patient name: _____ DOB: _____

Home phone:_____Cell:_____

Diagnosis:_____

The Rehab program will be offered 2-3 days per week for 12 weeks. Participants can expect to be in the clinic 1.5 to 2 hours per session. The sessions consist of exercise, group education, and individual counseling where appropriate. The patient is more likely to participate if the importance of exercise is discussed prior to the referral being sent. Please give patient the trifold pamphlet for our program.

☐ **Cardiac Rehabilitation-** Monitored exercise with the use of telemetry.

*Please fax recent AgA1c and fasting lipid profile, medication list and any procedure reports, stress test or echocardiogram results that pertain to the patient's cardiac diagnosis with referral.

☐ **Peripheral Artery Disease Rehab-** Monitored exercise with continuous SpO2 and HR.

*Please fax medication list with referral.

☐ **Pulmonary Rehabilitation-** Monitored exercise with continuous SpO2 and HR.

* Please fax a pulmonary function report if on file and medication list with referral.

By completing this referral I agree to be the ordering physician for the following blood work to be drawn pre and post Cardiac Rehab: HbA1c and fasting lipid profile. If ordering Pulmonary Rehab, I agree to be the ordering physician for a complete pulmonary function test if one has not been performed.

Referring Provider Information:

Referring Provider: _____

Office Phone: _____ Fax: _____

Signature: _____

Date: _____/_____/_____