

**Cardiac Rehabilitation
Preventive Cardiology
Cardiopulmonary Exercise Testing**

The University of Toledo
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**Cardiac Rehabilitation
Physician Order**

- Phase II Cardiac Rehab
- Phase III Cardiac Rehab
- Cardiopulmonary Exercise Testing

Patient's Name _____ SS# _____ Date of Birth _____

(Last) (First)

Medical Record # _____

Primary Diagnosis:

Patient Phone # _____

Secondary Diagnosis:

Cardiac History:

- | | | | |
|-------------------|--------------------------|----------|--------------------------|
| Angina | <input type="checkbox"/> | s/p CABG | <input type="checkbox"/> |
| s/p PTCA/Stent | <input type="checkbox"/> | s/p MI | <input type="checkbox"/> |
| s/p Valve Surgery | <input type="checkbox"/> | s/p OHT | <input type="checkbox"/> |

Symptoms and/or conditions requiring special considerations:

- | | | | |
|--------------|--------------------------|--|--------------------------|
| COPD | <input type="checkbox"/> | Arrhythmia | <input type="checkbox"/> |
| PAD | <input type="checkbox"/> | Orthopedic Limitations | <input type="checkbox"/> |
| Hypertension | <input type="checkbox"/> | Diabetes: Type | <input type="checkbox"/> |
| CHF | <input type="checkbox"/> | (Finger stick and blood glucose levels may be monitored pre and post exercise) | |

Other: _____

(Patient may use SL NTG 0.4 mg as prophylaxis for chest pain prior to exercise or per standing protocol for chest pain during exercise.)

I have examined the above-listed patient and have determined that his/her admission into the University of Toledo Medical Center's Cardiac Rehabilitation Program is medically necessary. I understand that it is a comprehensive program consisting of an exercise prescription, exercise therapy sessions, nutrition therapy and lipid management, and patient education regarding risk factor reduction. The patient will perform a cardiopulmonary exercise test during his/her stay in the program in order to provide an accurate exercise prescription. The patient will have a lipid profile performed. The patient's primary care physician will be notified about the treatment plan, any problems and the patient's progress upon completion of the program. Any limitations this patient may have are listed above.

Please send or fax form
to the above address

Physician Name (printed): _____

Physician Signature: _____

Date: _____