Patient Name:_____ DOB:_____

Date:_____ Phone:_____

Insurance:_____

Please specify phase:

❑ Cardiac rehabilitation phase 11
❑ Cardiac rehabilitation phase 111
❑ Supervised Exercise Therapy (SET) for symptomatic PAD

Diagnosis (please check all that apply):

❑ Angina _____ ❑ Valve repair / replacement _____
❑ CABG _____ ❑ Stents _____
❑ MI _____ ❑ PTCA _____
❑ Symptomatic PAD with Intermittent Claudication ❑ Right ❑ Left ❑ Bilateral
❑ Other _____

Exercise Prescription:

Mode: The exercise program, based on patient's tolerance, may include the following:

Recumbent bike	Airdyne Bike	Rower	Treadmill
Arm Ergometer	Strength Training (hand weights, bands)	Eliptical	

Please indicate any contraindications to the use of any of the above equipment,_____

Frequency: Three (3) days per week

Intensity: Target Heart Rate selections

70−75% of Maximum Heart Rate for age, or 20−30 beats above resting heart rate, unless otherwise specified

Specified Target Heart Rate Range: _____

Duration: Up to 60 minutes − as toleratd by patient

Rate of Progression: As tolerted by patient using Target Heart Rate and Rate of Perceived Exertion.

Please fax clinical information, including the following, to 603.609.6023:

❑ H&P ❑ Stress test ❑ EKG ❑ Operative Report ❑ Office note
❑ Discharge Summary ❑ Cardiac cath. ❑ Echo. ❑ Lipid profile

_____ _____
Physician Signature Date / Time

_____
Physician Name Printed

PHONE: 603.740.3323 **FAX: 603.609.6023**