

# Heart Healthy Living Exercise Classes

## RELEASE OF PATIENT INFORMATION / CARDIAC REHABILITATION REFERRAL FORM (Please print, complete and mail to the address below)

### Release of Patient Information (Client to complete)

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_, MN Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

I authorize \_\_\_\_\_ (Primary MD) \_\_\_\_\_ (Cardiologist)

\_\_\_\_\_ (Hospital) to release to Heart Healthy Living, P.A. records of the following to be used for my exercise plan and statistical research purposes.

- Latest History and Physical
- Latest Cardiology Consultant report
- Latest Echocardiogram
- Lipid Profile Lab Results
- Latest Angiogram/Angioplasty/Stent placement report
- Latest exercise stress test interpretation
- Latest 12 Lead EKG
- Operative report of cardiac surgery
- Last hospital discharge summary
- Current medication list

Client signature \_\_\_\_\_ Date \_\_\_\_\_

### ***I am interested in Heart Healthy Living Exercises***

- |   |                        |
|---|------------------------|
| <input type="checkbox"/> Edinborough Park - Edina       | MWF 7:00 – 8:15 a.m.   |
| <input type="checkbox"/> Sabes JCC – St. Louis Park     | MWF 8:45 – 10:00 a.m.  |
| <input type="checkbox"/> Eagan Community Center - Eagan | MWF 10:45 – 12:00 p.m. |
| <input type="checkbox"/> Southdale YMCA - Edina         | MWF 1:45 – 3:00 p.m.   |

### **Cardiac Rehab Referral (Doctor/Advanced Practice Nurse to complete)**

#### **Maximum heart rate guideline:**

- 20-30 bpm above resting heart rate  
 According to enclosed exercise test done within last 6 months

*I agree that this patient is capable of participating in an exercise program under the guidance of an exercise physiologist. This referral/order will be in affect for 1 year. I will be provided with a written progress report every 6 months.*

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(MD/Advanced Practice Nurse signature is needed for client referral (order) for client to participate.)

#### **Referring Physician/Advanced Practice Nurse Information:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ FAX \_\_\_\_\_



Send completed form to: Heart Healthy Living, P.A. Attn: Lorene Brown MS, RN, CNS  
120 Choctaw Circle, Chanhassen, MN 55317  
Tel: 612-242-1878 FAX: 952-934-4861