

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. |
| <input type="checkbox"/> Williston Fitness Center* - Minnetonka | MWF 4:00 – 5:15 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 RN and 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. * Registered Nurse Not Present at Williston Fitness Center, Minnetonka, MN.

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
E-Mail: hearthealthyliving@mchsi.com