ECHN
Eastern Connecticut Health Network, Inc.

MANCHESTER MEMORIAL HOSPITAL
71 Haynes Street, Manchester, CT 06040

ROCKVILLE GENERAL HOSPITAL
31 Union Street, Vernon, CT 06066

Outpatient Cardiac Rehabilitation and Secondary Prevention Referral/History and Physical

Patient Name: _____ **Phone Number:** _____

☐ Refer to Cardiac Rehabilitation

Cardiac Diagnosis:	**ICD–10**	**Date (month/year):**
☐ Myocardial Infarction	I21.3	_____
☐ CABG	Z95.1	_____
☐ PTCA ☐ Stent Placement	Z98.61	_____
☐ Valve replacement/repair – Mechanism	Z95.2	_____
☐ Valve replacement/repair – Tissue	Z95.3	_____
☐ Stable angina pectoris	I20.8/I20.9	_____
☐ CHF (Stable Class II–IV, LVEF <35%)	I50.9	_____
☐ Other:		_____

Hospital: _____

Manchester Memorial Hospital
Phone: 860–646–1222 X2166
Fax: 860–533–2933

Rockville General Hospital
Phone: 860–872–5171
Fax: 860–872–5125

Current Medications and Dosages:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Other Medical Conditions: _____
_____

PHYSICIAN ORDER

Exercise prescription to be completed by Medical Director or Cardiologist: ☐ Yes ☐ No

Special Instructions: _____

Frequency: _____ Duration: _____ Intensity: _____ Modalities: _____

Progression: _____

Stress Test deferred at this time: ☐ Yes ☐ No (Please submit a copy of stress test if available. For a medicare diagnosis of stable angina, please submit a copy of the positive stress test obtained within the past 6 months.)

If available, please enclose copies of the following: EKG, Lipid Profile, FBS, Surgical Note.

Do you want the following performed? (please check)

☐ EKG ☐ FBS ☐ Lipid Profile

I am referring the above named patient to participate in the Outpatient Cardiac Rehabilitation Program.

Phase II

_____
Practitioner/AHP Signature / Date / Time

_____
Print Name/Mnemonic

Phase III

_____
Practitioner/AHP Signature / Date / Time

_____
Print Name/Mnemonic

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Eastern Connecticut Health Network, Inc.

MANCHESTER MEMORIAL HOSPITAL
and
ROCKVILLE GENERAL HOSPITAL
affiliates of Eastern Connecticut Health Network, Inc.

CARDIAC REHABILITATION INFORMED CONSENT

I consent to enter a Cardiac Rehabilitation exercise program in order to attempt to improve my cardiovascular function. This program, which includes cardiovascular monitoring/supervision and health education, has been recommended to me by my physician.

Before I enter this program I will have a clinical evaluation performed by my physician. This will include a medical history and physical examination consisting of, but not limited to, measurements of heart rate, blood pressure, and electrocardiogram at rest. The purpose of this evaluation is to attempt to detect any condition, which would indicate that I should not engage in this exercise program.

The program will follow an exercise prescription prepared by my physician. I understand these activities are designed to place a gradually increasing workload on my cardiovascular system and thereby attempt to improve its function. The reaction of my cardiovascular system to such activities cannot be predicted with complete accuracy. There is a risk of certain changes occurring during and following the exercise. These changes include, but are not limited to, abnormalities of blood pressure or heart rate, an ineffective "heart function", and possibly in some instances, rare instances, of "heart attacks" or "cardiac arrest".

I realize that it is necessary that I promptly report to the Cardiac Rehabilitation staff any signs or symptoms indicating any abnormality or distress including but not limited to chest pain or pressure, undue shortness of breath, dizziness, faint feeling. I consent to the administration of medications and any immediate resuscitation that may be necessary in the event of a cardiac emergency.

The information which is obtained in this rehabilitation program will be treated as privileged and confidential and will consequently not be released or revealed to any person without my express written consent. I agree to the use of data from the exercise program for scientific and statistical purposes with my right of privacy protected. Any other information obtained will be used only by the program staff in the course of prescribing exercise for me, planning my rehabilitation program, or advising my personal physician of my progress.

This form has been fully explained to me and I have been given an opportunity to ask questions. I am satisfied that I understand its content.

Signed: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

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SUPERVISED EXERCISE THERAPY FOR SYMPTOMIC PERIPHERAL ARTERY DISEASE REFERRAL FORM

Supervised exercise therapy for PAD is a Class 1A recommendation for the treatment of peripheral arterial disease. Our program consists of qualified staff trained to provide exercise programs for individuals with PAD.

Patient's Name_____ **Phone Number** _____

Date of Order: _____ **Hospital** _____

Diagnosis: Symptomatic PAD with Intermittent Claudication Primary
ICD-10: Right leg **I70.211**_____
Left leg **I70.212** _____
B/L legs **I70.213** _____

Current Medications and Dosages

_____ _____
_____ _____
_____ _____
_____ _____

Other Medical Conditions:_____
_____

I am referring the above named patient to participate in the Outpatient Supervised Exercise Therapy for PAD.

MD Signature/Date/Time:_____

Print Name:_____

ECHN℠
Eastern Connecticut Health Network
The Communities' Choice℠ - www.echn.org

☐ MANCHESTER MEMORIAL HOSPITAL
71 Haynes Street, Manchester, CT 06040
(860) 646-1222, ext. 2166, Fax (860) 533-2933

☐ ROCKVILLE GENERAL HOSPITAL
31 Union Street, Vernon, CT 06066
(860) 872-5171, Fax: (860) 872-5125

Department of Cardiac/ Pulmonary Rehabilitation

Pulmonary Rehabilitation Referral Form

Date:_____
Patient Name:_____
Address:_____
_____
_____

Physician:_____
DOB:_____
Telephone:_____

Diagnosis:_____ Allergies:_____
Brief Medical History:_____
_____
_____
_____

Does your patient have any of the following:	Yes	No
History of non-compliance	☐	☐
Disabling arthritis or bone/joint disease	☐	☐
Uncontrolled heart failure	☐	☐
Poorly controlled diabetes	☐	☐
Cerebral vascular disease or paralysis	☐	☐

Other_____

Current Medications:_____
_____
_____
_____

I am referring the above named patient to be evaluated for participation in the Pulmonary Rehabilitation Program at ECHN, which includes breathing retraining, educational and exercise sessions for muscle strengthening and conditioning. This program meets two times per week for six weeks and includes an assessment prior to beginning the program.

Physician Signature: X_____ Date:_____
Address:_____ Telephone:_____
_____ Fax:_____

Please forward completed referral to: Cardiac/Pulmonary Rehabilitation Department
MMH Fax: 860-533-2933 or **RGH Fax**: 860-872-5125

Devised 3/5/08
Revised 9/4/12
PR patient referral