GRIFFIN HEALTH

GRIFFIN HOSPITAL PERIPHERAL ARTERY DISEASE SUPERVISED EXERCISE REFERRAL

PATIENT NAME: _____ DOB: _____

PT PHONE #: _____REFERRING M.D.: _____

(Please attach copy of patient's demographic information to include address and insurance)

Patient has been diagnosed with Peripheral Artery Disease (PAD) and meets the following criteria:

Symptomatic Intermittent Claudication: ICD-10: I 73.9: _____

Right Leg: _____

Left Leg: _____

Bilateral Legs: _____

Date of Office visit with referring MD: _____

Patient has received risk factor education and counseling with regard to his/her PAD and cardiovascular health: Date: _____

Current office note, pertinent labs and diagnostic reports, and medication reconciliation attached: ____

By signing below you are referring the above named patient to the supervised exercise PAD program at Griffin Hospital. You are stating that the above named patient is safe to exercise and does *not* have any of the following "absolute contraindications" to exercise: unstable angina, severe/symptomatic valve disease, critical limb ischemia, open wounds/blisters on feet).

Physician's Signature: _____ Date/Time: _____

Physician's Printed Name: _____

Address: _____

_____

Phone: _____ Fax: _____

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