Goshen Hospital

Cardiopulmonary Rehab Services
1855 South Main St., Suite B
Goshen, IN 46526
Office 574-364-2587 Fax 574-364-2531

Patient Name _____	Ordering Physician Signature _____
Date of Birth _____Social Security _____	Ordering Physician _____
Address _____	
City _____State _____Zip _____	Primary Care Physician _____
Telephone # _____	Send Copy To _____
	Fax Results To _____
Primary Insurance _____	
Primary Policy # _____Group # _____	Diagnosis #1 _____ICD-10 Code _____
	Diagnosis #2 _____ICD-10 Code _____
Secondary Insurance _____	Diagnosis #3 _____ICD-10 Code _____
Secondary Policy # _____Group # _____	Diagnosis #4 _____ICD-10 Code _____

PAD Supervised Exercise Referral Form

Date of referral: _____

❑ PAD Supervised Exercise program

For safety and exercise baseline, I authorize the following:

- **6 Minute Walk Test pre and post exercise program.**
- **Initiate/titrate supplemental oxygen PRN during exercise.**
- **Evaluation of:**
  - ✓ **Claudication**
  - ✓ **Functional Status**
  - ✓ **Walking Capacity**

- **Rehab staff to develop Exercise Prescription and recommendations, including CVD Education.**

❑ Other: _____

I hereby certify that the above patient is medically able to participate in an exercise program.

PLEASE FAX COMPLETED FORM TO
574-364-2531