GIRARD Medical Center

Outpatient Cardiac Rehab – PAD Referral form

Phone: 620-724-5126

Fax: 620-724-5127

Patient Information: **Date:**

Patient Name: _____ Date of Birth: _____

Address: _____

(City) (State) (Zip Code)

Phone: _____

Patient SS#:_____ Sex: M ☐ F ☐

Diagnosis:

☐ 170.212	Atherosclerosis of native arteries of extremities with intermittent claudication, left leg
☐ 170.213	Atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs
☐ 170.311	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication, right leg
☐ 170.312	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication, left leg
☐ 170.313	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication, bilateral legs
☐ 173.9	Peripheral vascular disease, unspecified with intermittent claudication

Secondary Diagnosis:

☐ Hypertension ☐ Hyperlipidemia ☐ Obesity ☐ Diabetes ☐ Congestive Heart Failure

Risk Factors:

☐ Age ☐ Smoker ☐ Cardiac Disease ☐ Previous Vascular Surgery ☐ Stroke/TIA

Physician Referral:

☐ **I have examined the patient listed above and educated the patient about Peripheral Artery Disease and the potential benefits of an exercise program. I have determined that his/her admission into the Peripheral Artery Disease Exercise Program is medically necessary.**

Physician's Name (please print):_____

Physician's Signature:_____ Date:_____ Time:_____

Office Phone#: _____ Office Fax#:_____

Please fax copy of face sheet, labs, medical history, last progress note, medication list and results of ABI or CTA to: 620-724-5127.