

Primary Care EXERCISE CLINIC REFERRAL

Any health professional may complete this referral form; but, it must be signed by a physician, physician's assistant, or nurse practitioner. Please be sure the form is legibly completed. Incomplete or illegible forms will be returned and the processes delayed.

Patient's Primary Care Physician: \_\_\_\_\_ phone: \_\_\_\_\_

Patient's name and address: \_\_\_\_\_

Patient's phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Patient can travel independently: Yes <input type="checkbox"/> No <input type="checkbox"/>	Patient's Date of Birth: _____
<b>Reason for referral:</b>	
<p><b>Cardiovascular</b></p> <p>Hypertension <input type="checkbox"/> Heart Failure <input type="checkbox"/> PVD <input type="checkbox"/> Arrhythmias <input type="checkbox"/>          Previous MI <input type="checkbox"/> CABG <input type="checkbox"/> PTCA <input type="checkbox"/> Ischemia <input type="checkbox"/>          Other <input type="checkbox"/> _____</p> <p><b>Metabolic</b></p> <p>Diabetes <input type="checkbox"/> Obesity (BMI &gt;30 kg/m<sup>2</sup>) <input type="checkbox"/> Dyslipidemia <input type="checkbox"/>          Other <input type="checkbox"/> _____</p> <p><b>Musculoskeletal</b></p> <p>Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/>          Other <input type="checkbox"/> _____</p> <p><b>Pulmonary</b></p> <p>Asthma <input type="checkbox"/> COPD/Emphysema (Non-O<sub>2</sub> Dependent Only*) <input type="checkbox"/>          Other <input type="checkbox"/> _____</p> <p><b>Other</b></p> <p>Parkinson's Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/>          Other <input type="checkbox"/> _____</p> <p><small>*We do not have the ability to provide supplemental oxygen during exercise</small></p>	

\_\_\_\_\_ is being referred to the University of Mary Exercise  
(Patient name)

Clinic on: \_\_\_\_\_ by: \_\_\_\_\_  
(Date) (Referring healthcare provider: NP, PA, MD, DO)

This patient may participate in supervised site-based exercise sessions \_\_\_\_ and unsupervised professionally prescribed home exercise \_\_\_\_\_. (Please initial one or both)

Patient or Practitioner: To schedule the first appointment, contact the Exercise Physiology Department at 355-8236 or fax this form to "Attn. Kayla Dressler, Exercise Clinic Coordinator" at the University of Mary, fax: (701)355-8313