Supervised Exercise Therapy Referral

NMC health

PO Box 308 | Newton, KS 67114

Patient Name: _____ DOB: _____

Phone: _____ Phone (other): _____

Primary Insurance: _____ ID #: _____

Please indicate below the specific arteriosclerosis diagnosis with symptomatic intermittent claudication:

Diagnosis	Right Leg	Left Leg	Bilateral Legs	Other
Atherosclerosis of native arteries of the extremities with intermittent claudication:	☐ I70.211	☐ I70.212	☐ I70.213	☐ I70.218
Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication:	☐ I70.311	☐ I70.312	☐ I70.313	☐ I70.318
Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication:	☐ I70.411	☐ I70.412	☐ I70.413	☐ I70.418
Atherosclerosis of non-autologous biological bypass graft(s) of the extremities with intermittent claudication:	☐ I70.511	☐ I70.512	☐ I70.513	☐ I70.518
Atherosclerosis of nonbiological vein bypass graft(s) of the extremities with intermittent claudication:	☐ I70.611	☐ I70.612	☐ I70.613	☐ I70.618
Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication:	☐ I70.711	☐ I70.712	☐ I70.713	☐ I70.718

STANDARD TREATMENT PLAN

Frequency: 3 exercise sessions per week for 12 weeks.

Intensity: Begin and progress within the following parameters:
Rate of Perceived Exertion OMNI Scale 0-10
MPH/Grade determined by evaluation test
Mode: Treadmill, NuStep, or other as appropriate
Time/Duration: A goal of 30-60 minutes of total session time.

REFERRING PROVIDER STATEMENT

☐ I assert that I have had a face-to-face visit with the patient and provided information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

Provider Comments: _____

_____

Referring Provider Signature _____ Date: _____