# HEART for LIFE
## Cardiac Support and Education Program
## Registration/Referral Form

Date: ____________________

Name: ________________________ Phone: (w) __________ (h) ___________

Address: ________________________ Birthdate: ____________________________
________________________

Family Physician: ________________________ Cardiologist/Internist: _____________________

Surgeon: ________________________ Heart Attack Date: _____________________

Bypass Surgery Date: _________________ Angioplasty Date: _____________________

Angina Date: ________________________ Heart Transplant Date: _____________________

Other Medical Concerns: ____________________________________________________________________

Stress Test:
Date: _________________
METS achieved: _________________
Resting Heart Rate: _________________ Maximum Heart Rate: _____________________
Resting Blood Pressure: _________________ Maximum Blood Pressure: _____________________
End Point: ____________________________________________________________________
Comments: ____________________________________________________________________

Exercise Prescription:
Functional Capacity6 (% of VOx max): ____________
Target Heart Rate: ____________
Target MET Level: ____________
Time of Aerobic Exercise: ____________

Exercise Routine:

Treadmill: Speed ____________
Incline ___________
Time ________mins.

Stationary Bike: Speed 50 – 60 rpm
% Resistance ________watts
Time ________mins.

Arm Ergometer: Speed 50 – 60 rpm
Resistance ________watts
Time ________mins.

Symptoms/Precautions to Exercise: _________________________________________________________
_____________________________________________________________________________________

One University. One World. Yours.

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