

TriHealth



Fitness & Health

Pavilion

6200 Pfeiffer Road
Cincinnati, OH 45242

Phone (513)985-0900 Fax (513)985-0918

Please Print

Patient Phone _____

Patient Name _____

Date _____

Treating Physician _____

Release Date _____

Cardiac Rehab Nurse _____

Phone _____

Rehab Nurse Address _____

Date of last stress test _____

Current Status at Discharge _____

Restrictions/Precautions _____

Is there a **MAXIMUM HEARTRATE** this patient should not exceed during aerobic exercise?
Yes or No Please specify: _____

Are you aware of any medication this patient is taking regularly that would affect his/her response to exercise? If so, please describe.

Other Notes _____

What components of the fitness assessment do you wish patient to participate in?

- Resting Heart Rate Resting Blood Pressure Height Weight
- Strength (push ups and hand grip) **Yes or No** Body Composition **Yes or No**
- Sub-max VO2 Bicycle Ergometer Test **Yes or No**
- Sit and Reach Flexibility Test **Yes or No**

Aquatics **Yes or No** Specify? _____

Comments _____
