

Dear Physician:

DOB: \_\_\_\_\_

Your patient, \_\_\_\_\_ wishes to participate in the Phase IV Maintenance Exercise Program without formal supervision at Cardiac Rehabilitation at Medical Center of Lewisville. Your patient needs your approval to participate. The patient has indicated on their health history form that they have the following conditions.

Conditions: \_\_\_\_\_

\_\_\_\_\_

Please indicate below if there are any exercise limitations for this patient.

Limitations: \_\_\_\_\_

\_\_\_\_\_

Use Standard Orders for:

1. Nitroglycerin 0.4 mg SL q 5 min X 3 if angina pain persists: Physician to be notified.
2. ACLS protocols for emergencies.
3. Oxygen 2-3 L/min continuous until angina pain resolved or new orders from physician.

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_

Phone #

Fax #

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

Thank you for your support of our program. Please fax this form to: 972-219-7506

Cardiac Rehab  
Medical Center of Lewisville  
500 W. Main Street Lewisville, Texas 75057  
Phone: 972-420-1526 Fax: 972-219-7506