

Appendix P

Cardiac Rehabilitation Untoward Event— Physician Notification

Patient name: _____ DOB: _____ Date: _____

To: Physician _____ Date physician notified: _____

Time physician notified: _____

Phone: _____

Fax: _____

Physician orders:

- _____ May resume CR at next scheduled visit
- _____ May not resume CR until _____
- _____ Limit exercise as directed below
- _____ Will be evaluated on _____
- _____ No follow-up needed

Additional physician orders or comments:

Physician signature: _____ **Date:** _____

Please return this page, completed and signed, to Cardiac Rehabilitation.

Patient name: _____ DOB: _____ Diagnosis: _____

Date of event: _____ Time: _____ Rehab week/visit #: _____

Reason for report:

- _____ New sign or symptom
- _____ Change from previous condition
- _____ Findings exceed acceptable parameters
- _____ Other: _____

Attach appropriate physiological data such as 12-lead ECG, BP measurement, code form, and so on.

From *Guidelines for Cardiac Rehabilitation and Secondary Prevention Programs, Fifth Edition*, by American Association of Cardiovascular and Pulmonary Rehabilitation, 2013, Human Kinetics, Champaign, IL.

Type of event:

- ☐ Angina symptoms
☐ Dysrhythmia or ECG changes
☐ BP abnormality
☐ Dyspnea or abnormal O₂ saturation
☐ Heart failure symptoms
☐ Blood glucose abnormality
☐ Other: _____

Description of occurrence: _____

Description of action:

- ☐ Managed by rehab staff
☐ Seen in rehab by supervising physician
☐ Transferred to emergency room
☐ Sent to clinic or physician office
☐ Appt made with _____ on _____

Treatment:

- ☐ NTG _____ mg × _____
☐ Oxygen @ _____ L/m
☐ 12-lead ECG
☐ Aspirin _____ mg

Recommendations: _____

Disposition:

- ☐ ER
☐ Physician's office or clinic
☐ Home

Accompanied by:

- ☐ Self
☐ Spouse/family
☐ Rehab staff
☐ Other

Status upon departure:

- ☐ Stable
☐ Unstable
☐ Other

Report completed by: _____

Attach appropriate physiological data such as 12-lead ECG, BP measurement, code form, and so on.

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