THE NEWYORK-PRESBYTERIAN/QUEENS
CARDIAC HEALTH CENTER
174-03 Horace Harding Expressway
Fresh Meadows, NY 11365
Phone: 718-670-1695 Fax: 718-357-0957

Thank you for your interest in the Cardiac Health Center.

This packet includes the following forms:

1. PHYSICIAN referral Form (to be completed by your cardiologist/PMD)
2. Cardiac Risk Profile
3. Patient Authorization (permission to obtain medical records)
4. Patient Authorization 2 (permission to speak to another family member)
5. PHQ
6. Health Quiz

Please print and complete forms 2 through 6 and bring them with you to your orientation appointment. **PLEASE DO NOT COMPLETE FORM 1 – PHYSICIAN REFERRAL FORM**. If you have an appointment scheduled with your physician prior to orientation, please have him/her complete the form.

Any questions feel free to contact us.

Thank you.

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PHYSICIAN REFERRAL FORM

Name: _____ DOB: _____ Sex: F M

Address: _____ Patient Phone: _____

_____

Referring MD: _____ MD Phone: _____

♥ **Cardiovascular Diagnosis indicating the need for Cardiac Rehabilitation and Prevention**

Date

	Myocardial Infarction (specify site)		
	Coronary Artery Bypass	Z95.1	
	Stable Angina Pectoris	I20.9	
	Coronary Atherosclerosis/PTCA with stent	Z95.5	
	Coronary Atherosclerosis/PTCA without stent	Z98.61	
	Valve replacement	Z95.2	
	Heart Transplant	Z94.1	
	CHF (EF< 35)		

Code for MI location (STEMI)		
	Unspecified	I 21.3
	Anterior wall	I 21.09
	Inferior wall	I 21.19
	Inferior posterior	I 21.11
	Lateral wall	I 21.29
	Anterolateral	I 21.09
	Non-STEMI MI	I21.4

♥ **Your patient will be counseled on a low fat, limited added sugars, and low sodium diet unless you specify otherwise.**
Low fat: 30% total, 10% saturated, 10% monounsaturated, 10% polyunsaturated, 2gm sodium daily.

Other: _____

♥ **An Exercise Stress Test, post event and within 3 months is required prior to the start of the program.**
Please mark your preference:

I will perform the exercise stress test in my office _____

OR

The Cardiac Health Center may perform the pre and post exercise stress tests _____

♥ **PLEASE SPECIFY:**

_____ **PHASE II: Physician Supervised EKG MONITORED Exercise program(3 times per week, 1 hour, up to 36 sessions)**
For patients with known heart disease*: Medicare reimburses for* recent MI, CABG, Stable Angina, Angioplasty with stent, Valve repair/replacement, and Heart Transplant, CHF. If diagnosis older than six months please indicate if complications/ reasons for delay.

_____

_____ **Prevention/ Maintenance Program- Exercise and Education - 3 times per week, 1 hour, 36 sessions.**

The above named patient has been medically cleared and has my permission to be enrolled in the NY-P/Q Cardiac Health Center rehabilitation and risk reduction program at the Cardiac Health Center. I will continue the regular care of my patient throughout the duration of the program.

♥ **MD SIGNATURE** _____ **Date:** _____

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Cardiovascular Risk Profile

NAME _____

ADDRESS _____

_____

HOME PHONE:_____CELL PHONE_____

E-MAIL ADDRESS:_____BUS. PHONE_____

CARDIOLOGIST NAME _____PHONE#_____

FAX#_____

ADDRESS_____

MEDICAL INTERNIST_____ PHONE#_____

FAX#_____

ADDRESS_____

WHO REFERRED YOU?_____

PREVIOUS REHABILITATION PROGRAM (IF ANY):_____

Date of birth _____/_____/_____ Birthplace_____ Age_____Sex: ☐Male ☐ Female

Are you a veteran? ☐ No ☐Yes Mother's first name_____Father's first name_____

FINANCIAL INFORMATION: MEDICAID #_____ MEDICARE#_____

OTHER INSURANCE_____ Social Security#_____

RELIGION_____RACE_____

Marital Status: ☐ Married ☐ Single ☐Divorced ☐ Widowed Native/Preferred Language_____

Highest level of education: ☐Elementary ☐ Some High School ☐ Completed High School ☐College

Occupation _____ Are you: ☐Full time ☐ Part time ☐ Retired

If working: Employer _____

Height_____ Weight_____ *Desired weight_____

Emergency Contact: RELATION TO PATIENT_____

Name_____Date of Birth_____

Address_____

Phone:_____

CARDIAC HEALTH CENTER

Name _____

Please **check all that apply**:

DIAGNOSIS:

( )Heart bypass(CABG) surgery Date_____
( )Heart Attack Date_____
( )**Stent**/Angioplasty Date_____
( )Valve repair/replacement Date_____
( )Heart/lung transplant Date_____
( )Angina,
( )Heart failure
( )Irregular heart rate_____
( )Pacemaker, ( )Defibrillator
( )High Blood Pressure
( )Diabetes,
( )High Cholesterol
( )Smoker ( ) Prior Smoker: STOPPED_____ #YEARS_____ #PACKS PER DAY_____
( )Family history of heart disease:_____
( )Sedentary (Not exercising regularly)
( )Depression
( )**Other** _____

Did you receive the flu shot? YES( ) NO( )
Did you receive the pneumonia vaccine? YES( ) NO( )

MEDICATIONS: Please list all medications that you currently take:

NAME	DOSE	FREQUENCY	PURPOSE

ALLERGIES: Do you have any Drug allergies? ☐**No** ☐**Yes** If yes**:** medication name **and** reaction**:** _____

I require information on my present medications. ☐No ☐Yes

I learn best by: ☐ Verbal instructions ☐ Video ☐Written instructions ☐All of the methods described +

Signature _____ **Date** _____ **Time** _____ 9/16 dc/gd

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Patient Authorization

Date_____

Re: _____

Date of Birth_____

I authorize my physician and other health care institutions to release all of my medical records, including medical tests, evaluations, and progress notes to the Cardiac Health Center.

_____ _____
Signature of Patient Date/Time

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Patient Authorization 2

Date_____

Re: _____

Date of Birth_____

I authorize the Cardiac Health Center to call my home/cell phone and leave messages.
I authorize the Center's staff to speak about my program or condition/and medical condition to my
( ) spouse ( )child/children ( ) significant other _____
Print Name
( ) Other_____.
Print Name

_____ _____
Signature of Patient Date/Time

1/16dc

Cardiac Health Center - PHQ

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult At All	**Somewhat Difficult**	**Very Difficult**	**Extremely Difficult**
□	□□	□	□

I agree to release the results of this mood evaluation questionnaire to my referring heart doctor or family Doctor.

_____ _____

Signature **Date**

TOTAL SCORE: _____

□ Patient referred to_____ for follow up on depression scale results.
□ Patient referred to his/her cardiologist for follow up on depression scale results.
□ Patient referred to his/her PMD for follow up on depression scale results.
□ Discussed questionnaire results with patient.
□ Patient verbalized understanding
□ Patient did not verbalized understanding.

□**Mild Depression 5-9**
□**Moderate Depression 10-14**
□**Severe Depression >15**

Plan for follow up: _____

Staff Signature: _____ Date_____ Time_____

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Pre/Post Education Assessment

Circle or write in the correct answer.

Name:_____

1. What is target heart rate?
    a. How fast your heart should beat at rest.
    b. How fast your heart should beat while exercising.
    c. How fast your heart should beat during cool down.

2. What is the best way to take your heart rate?
    a. Using any four fingers at the wrist.
    b. Using two fingers at the side of the neck.
    c. Using the thumb at the wrist.

3. There are seven **major risk factors for heart disease**. Can you name 2 of them?
    1. _____
    2. _____

4. Which of the following blood pressure can be considered the first stage of hypertension (high blood Pressure)?
    a. 120/80
    b. 140/90
    c. 180/90

5. What is one thing you can do to reduce high blood pressure?
    i. _____

6. Saturated fat can increase cholesterol levels in the blood. Where is saturated fat found?
    a. Animal fat (meats and dairy products)
    b. Vegetable oil
    c. Olive oil

7. What is the name for the “good” cholesterol?
    a. LDL
    b. HDL
    c. Triglycerides

8. When should you stop exercising?
    a. When you feel sweaty.
    b. When you are breathing heavier than normal.
    c. When you feel dizzy or nauseous.

9. How do you know if your blood pressure is too low?
    a. When it is 100/60
    b. When it is 90/50
    c. When I feel symptoms like dizziness or lightheadedness.

10. True or False: Depression is a feeling of sadness and/or little interest or pleasure in doing things.