THE University of Vermont HEALTH NETWORK

Elizabethtown Community Hospital

SET PAD Physician Referral Form

I have referred the following patient to your Supervised Exercise Therapy for monitored exercise, risk factor modification, and heart disease education.

Patient's Name: _____ DOB: _____ Phone: _____	Patient's Address: _____ _____

PERIPHERAL ARTERY DISEASE (date of onset):

Must be: ☐ Symptomatic; and had: ☐ Risk Reduction Counseling

Right Leg ABI: _____ **Left Leg ABI:** _____

LIMITATIONS SET BY REFERRING PHYSICIAN:

Please Select the appropriate ICD-10 Code:

Atherosclerosis of native arteries of extremities with intermittent claudication	**Atherosclerosis of unspecified type of bypass grafts of extremities with intermittent claudication**
☐ I70.211 Right Leg ☐ I70.212 Left Leg ☐ I70.213 Bilateral Legs ☐ I70.218 Other Extremity	☐ I70.311 Right Leg ☐ I70.312 Left Leg ☐ I70.313 Bilateral Legs ☐ I70.318 Other Extremity
Atherosclerosis of nonbiological bypass grafts of extremities with intermittent claudication	**Atherosclerosis of other type of bypass grafts of extremities with intermittent claudication**
☐ I70.611 ☐ I70.612 ☐ I70.613 ☐ I70.618	☐ I70.711 ☐ I70.712 ☐ I70.713

Referring Physician's Office Contact Information

Practice Name _____

Address _____ Phone Number _____

_____ Fax Number _____

Physician Signature: _____ Date: _____

Physician Name (please print): _____

AACVPR CERTIFIED PROGRAM

75 Park Street PO Box 277 Elizabethtown, NY 12932

(518) 873-3170 PHONE (518) 873-9002 FAX

Form revised 1-4-18