Cardiopulmonary Rehabilitation Department
2100 Wescott Dr. 5th Floor | Flemington NJ 08822
Tel (908) 788-6371|Fax (908) 788-6162

Welcome to our Cardiopulmonary Rehabilitation Department!

We are sending you this letter is to confirm your evaluation appointment for the Cardiac Rehab Phase II Program on: We are located in the main hospital on the 5th floor.

To prepare for your appointment, our staff will do a curtesy call to your insurance company to verify eligibility and coverage. We will inform you of any deductibles, copays or requirements before your appointment. In addition, our staff will request from your physician, all records needed to enroll in Cardiac Rehabilitation.

Here are a few things we are requesting from you to get ready for your upcoming evaluation:

1. ***Eat a light meal:*** If you are diabetic, we do ask that you have a light meal before your scheduled appointment and remember to bring your glucometer (if you have one).
2. ***Dress comfortably*****:** We recommend dressing in layers. Sweat pants and/or shorts, T-shirts, and supportive shoes with soft heel / sneakers. Locker rooms are available for changing and storing personal items.
3. ***Medications list:*** Please bring an updated list of all medications you are presently taking (including over-the-counter and supplements).
4. **Admission forms:** Please complete the forms and bring them to your appointment. Remember to bring your glasses (if you need them for reading). If you were unable to complete the forms in advance please arrive earlier to complete them the day of your appointment.
5. ***Register:*** We do ask that you arrive 20-30 minutes early on the day of your appointment and register with our *Admitting Department*. This department is located in our 1st floor lobby as you walk in to Hunterdon Medical Center. They will require a photo ID and your insurance cards, please bring these with you.

We look forward to your scheduled evaluation for Cardiac Rehab, if you have any questions or you are unable to keep your appointment, please contact us at (908) 788-6371. Kindly remember we require a 48-hour notice to cancel or reschedule.

Hunterdon Medical Center
Cardiopulmonary Rehabilitation Department
2100 Wescott Drive, Flemington, NJ 08822
908-788-6371, Fax 908-788-6162

Patient Contact Sheet
Admission Assessment

Patient label:

Preferred contact number: May we leave a message:

1. Your Home number:_____ ( ) ( )
2. Your Work number: _____ ( ) ( )
3. Your Cell number: _____ ( ) ( )
4. I hereby give permission to the Cardiopulmonary Rehabilitation Department at Hunterdon Medical Center to disclose information regarding my treatment to:

   Spouse:_____

   Son/Daughter:_____

   Other relative:_____

   Physician:_____

5. In case of an EMERGENCY, my CONTACT person is:
   (Please make sure the name & number given is a number that can be reached during the time you will be in rehab.)

   Name:_____ relation:_____

   Preferred number(s):_____

Diagnosis/conditions under Medical Care Treatment	Doctor's Name :	Next appointment:
Family Physician:		
Cardiologist:		
Pulmonologist:		
Endocrinologist:		

6. Do you have an advanced directive or living will?
   □ Yes **if yes, please bring a copy to your next visit**
   □ No if no, would you like information? □ Yes □ No: date given_____

Patient Signature:_____ ***Date:***_____

Staff Initials:_____

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Admission Assessment

Patient Name_____
Address:_____
_____
Date of Birth:_____age: _____
(Place Patient Label Here

Date completed:_____

HEALTH HISTORY / REVIEW OF SYSTEMS:

General Health	Yes	**Cardiovascular**	Yes	**Respiratory**	Yes
Good general health lately		CVA / Stroke / TIA		COPD	
Eyes		Endarterectomy		Emphysema	
Poor vision / glasses / contacts		Heart attack: STEMI / NSTEMI		Chronic Bronchitis	
Glaucoma / Cataracts		Angioplasty (Stent/ no stent):		Chronic Asthma	
Macular degeneration		Heart Bypass:		Interstitial lung disease	
Retinopathy		Rheumatic Fever		Sarcoidosis	
Ears/Nose/Mouth/Throat		Valve disease:		Cystic Fibrosis	
Hx. of ear disease:		Valve surgery / repair:		Pulmonary Fibrosis	
Deafness / hearing aid:		Heart transplant:		Lung Transplant:	
Gastrointestinal		Atrial Fibrillation post surgery		Reduction / Lobectomy :	
GERD / reflux / heartburn		Pleural effusion post surgery		Tuberculosis	
Ulcer Disease		complications s/p surgery		Pneumonia	
Liver disease		Palpitations / irregular rhythm		Hay Fever / frequent colds	
Constipation / diarrhea		Angina:		Sleep Apnea / use CPAP	
Bowel / Crohn / IBS		LVAD		Exposure to asbestos	
Genitourinary		Pacemaker		Exposure to fumes/chemicals	
Kidney/Renal disease		Internal defibrillator / life vest		Oxygen use:	
Dialysis		Heart failure:		**Neurological**	
Incontinence		Cardiomyopathy		Spinal cord injury	
Erectile Dysfunction: Viagra/cialis/		PVD/ claudication / Leg pain		Seizure disorder / tremors	
Musculoskeletal		Phlebitis / clots		Numbness/ Tingling	
Arthritis: osteo / rheumatoid		Hypertension / High BP		Neuropathy/change in sensation	
Bursitis		High Cholesterol / triglycerides		Difficulty with balance	
Osteoporosis		**Family Hx.:**		Dizziness / Fainting	
Connective Tissue disease				Psychiatric	
Chronic Back / neck pain		**Endocrine**		Anxiety / panic attacks	
Chronic Hip / knee pain		Diabetes: Type 1 / Type 2		Depression	
Myalgia / swelling / stiffness		Thyroid disease		Changes in Memory	
Restricted movement		Anemia / bleeding disorder		Insomnia	
Use of assistive device		Bloodborne: hepatitis / HIV / Lyme		Other:	
		MRO: MRSA / VRE / c-diff		**Cancer:**	
Surgeries:				Chemotherapy / radiation	

Clinician Initials:_____

Patient label:

Work History:

1. Currently employed? □ Yes, Occupation:_____ Employer:_____
   □ No; □ Retired, □ on disability, □ Unemployed, □ Other:_____
2. Does your job: involve lifting? □ No, □ Yes, how much:_____
   Occupational exposures? □ No, □ Yes, describe:_____
3. Plans for returning to work?_____

Exercise/Activities:

1. Did you exercise BEFORE your event? □ No, □ Yes, if yes, how recent was the last time:_____
   What kind of exercise:_____
   How many days/week:_____ How long:_____
2. Are you exercising now? □ No, □ Yes, if yes:
   What kind of exercise:_____
   How many days/week:_____ How long:_____
3. List exercise equipment in your home:_____
4. What activities, hobbies do you like to do?_____
5. Do you have any questions or concerns with intimacy? □ No, □ Yes:_____
   - Do you have a prescription for: □ Viagra, □ Cialis, □ Levitra

Lifestyle History / Activities of Daily Living:

1. Do you feel you can take care of your self? □ Yes/independent, □ No- Who assists?_____
2. Household duties you can do:_____
3. Are there activities that are difficult for you to do that you would like to do i.e. (CIRCLE): showering, dressing, stairs, walking, cooking, housecleaning, yard work ? _____
4. Do you feel rested upon awakening □ Yes □ No, if no, describe_____
5. Do you have sleep problems, describe:_____

Psychosocial history:

1. Marital Status: □ single, □ married, □ other committed relationship, □ divorced, □widowed
   -If married, how many years? _____
2. Who lives with you? _____
   How many children do you have?_____ How many Grandchildren?_____
3. Where do you get your biggest support during these trying times_____
4. Is spirituality important to you? _____
5. Do you have a social network?_____
6. Are there any ethnic customs, religious requirements or nationality preferences that influence your lifestyle?_____
7. Do you have any financial concerns that affect your ability to maintain your health? ( ) No, ( ) Yes
   If yes, explain_____
8. Describe your present mood, i.e.: □ down, □ depressed, □ Anxious, □ hopeless, □ have little or no interest or pleasure in doing things, □ indifferent, □ angry, □ upbeat, □ positive
   □ Other: _____
9. Are you being treated for depression (counseling/medication)?_____
10. Do you have thoughts of Suicide? □ No, □ Yes, if yes: Do you have a plan?_____
    If yes to both questions, complete "Columbia-Suicide Severity Rating Scale"
11. Do you feel safe in your home? □ Yes, □ No, describe_____
12. What are your Stressors/recent life changes? _____
13. How do you react in difficult or stressful situations? □ talk things out, □ Angry, □ yell, □ hold things in, □ cry, □ remain calm, □ Other_____

Patient label:

Tobacco / Alcohol /other substances:

1. Do you use any nicotine products? □ Never, □ former □ Yes, if former or yes, what kind:
   □ smoke cigarettes, □ cigars / pipe, □ chew tobacco, □ chew or dip tobacco
2. Smoke history: _____packs/day for _____ years = _____pack-years
3. Number of attempts to quit?_____ How: _____
4. Quit: _____ years ago; Use of nicotine replacement of pharmacologic:_____
5. Do you want to quit? □ No, □ Yes; what is preventing you_____
6. Do you live with someone who smokes? □ No, □yes; _____
7. Do you drink alcohol? □ No, □ yes, if yes, how much?_____
   What kind: □ light beer, □ beer, □ wine, □ liquor:_____
   how often? □ Daily, □ weekly, □ weekends only, □ monthly, □ several/month, □ socially
8. Do you use ? □ marijuana, □ cocaine, □ heroin, □ other:_____

Learning Preferences:

1. Primary Language: □ English, □ Spanish, □ Other:_____
2. Do you have any problems with vision, hearing or speech? □ No, □ Yes,
   If yes, explain:_____
3. Highest education level? □ Grammar, □ High school, □ College, □ advanced degree(s):_____
4. Do you have trouble reading written information? □ No, □ Yes,_____
5. Are you confident filling out medical forms independently? □ No, □ Yes
6. How do you like to learn? □ Reading, □ Discussion, □ Hands on training, □ Video/DVD,
   □ Lecture, □ Internet, □ talking 1:1 with health professional
7. How motivated are you to participation in education classes?
   □ motivated, eager to learn, □ indifferent, □ not interested
8. The most important things I want to learn or have concerns:
   _____

Additional comments: _____
_____
_____
_____
_____
_____

Clinician use only:

Who completed assessment? □ patient, □ Spouse, □ Friend, □ Other:_____
Arrived for appointment by: □ walked, □ cane / walker, □ wheelchair,
Assistance? □ No, □ yes; if yes, who?_____

Source: □ reliable, □ poor historian, □ Other:_____

The above information has been reviewed with the patient.
□ Admission Assessment: *Deferred ROS—page one, history provided in medical records*
The medical information / history is verified by the following documents:
□ physician office note: (date):_____
□ Stress test, □ Cath. report, □ echo, □ PFT

Clinician signature:_____ Date:_____ Time: _____

Patient Label: CII ( ) / PII ( ) Pre / Post

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

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**
☐	☐	☐	☐

Cardiopulmonary Rehabilitation Department
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Pt. label

Minnesota Living With Heart Failure Questionnaire

CII-HF: Pre / Post

Heart failure can affect all areas of your life if not treated properly. **Read each question and circle the number** (0, 1, 2, 3, 4, or 5) **that applies to you** and how you have been affected in the last 4 weeks.
If a question does not apply to you, circle the 0 after that question.

Did your heart failure prevent you from living as you wanted during the past 4 weeks by:	**No**				**Very Little**	**Very Much**
1. causing swelling your ankles or legs?	0	1	2	3	4	5
2. making you sit or lie down to rest during the day?	0	1	2	3	4	5
3. making your walking about or climbing stairs difficult?	0	1	2	3	4	5
4. making your working around the house or yard difficult?	0	1	2	3	4	5
5. making your going places away from home difficult?	0	1	2	3	4	5
6. making your sleeping well at night difficult?	0	1	2	3	4	5
7. making your relating to or doing things with your friends or family difficult?	0	1	2	3	4	5
8. making your working to earn a living difficult?	0	1	2	3	4	5
9. making your recreational pastimes, sports or hobbies difficult?	0	1	2	3	4	5
10. making your sexual activities difficult?	0	1	2	3	4	5
11. making you eat less of the foods you like?	0	1	2	3	4	5
12. making you short of breath?	0	1	2	3	4	5
13. making you tired, fatigues, or low on energy?	0	1	2	3	4	5
14. making you stay in a hospital?	0	1	2	3	4	5
15. costing you money for medical care?	0	1	2	3	4	5
16. giving you side effects from treatments?	0	1	2	3	4	5
17. making you feel you are a burden to your family or friends?	0	1	2	3	4	5
18. making you feel a loss of self-control in your life?	0	1	2	3	4	5
19. making you worry?	0	1	2	3	4	5
20. making it difficult for you to concentrate or remember things?	0	1	2	3	4	5
21. making you feel depressed?	0	1	2	3	4	5

CLINICIAN USE only	Totals						
					Total Score		

Patient label:

Dartmouth COOP Project – Quality of Life Survey

Cardiopulmonary Rehabilitation Department

Circle: **CII /PAD, Pre / Post, Test Score:_____**

Complete the following questions, based on how you have felt during the *last 4 weeks* by **circling the number that best describes*:***

1. **Physical Fitness:** What was the hardest physical activity you could do for at least 2 minutes?

Very heavy (for example) I can run at a fast pace, carry a heavy load upstairs or up hill weighing 25 lbs/10kgs or more	1
Heavy (for example). I can jog at a slow pace, climb stairs or a hill at a moderate pace.	2
Moderate (for example). I can walk at a fast pace, carry a heavy load on level ground weighing 25 lbs/10kgs or more	3
Light (for example). I can walk at medium pace, carry a light load on level ground weighing 10lbs/5 kgs or more	4
Very light (for example). I can walk at a slow pace. I can wash dishes	5

2. **Feelings:** How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted and blue?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

3. **Daily Activities:** How much difficulty have you had doing your usual activities or task, both inside and outside the house because of your physical and emotional health?

No difficulty at all	1
A little bit of difficulty	2
Some difficulty	3
Much difficulty	4
Could not do	5

4. **Social Activities:** Has your physical and emotional health limited your social activities with family, friends, neighbors or groups:

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

5. **Pain:** How much bodily pain have you generally had?

No pain	1
Very mild pain	2
Mild pain	3
Moderate pain	4

Patient label:	
	5

6. **Social Support:** Was someone available to help you if you needed and wanted help?

For example if you: felt very nervous, lonely, or blue
got sick and had to stay in bed
needed someone to talk to
needed help with daily chores
needed help just taking care of yourself

Yes, as much as I wanted	1
Yes, quite a bit	2
Yes, some	3
Yes, a little	4
No, not at all	5

7. **Change in Health:** How would you rate your overall health now compared to 4 weeks ago?

Much better ++	1
A little better +	2
About the same =	3
A little worse -	4
Much worse --	5

8. **Overall Health:** How would you rate your health in general?

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

9. **Quality of life:** How have things been going for you during the past 4 weeks?

Very well: could hardly be better	1
Pretty Good	2
Good & bad parts…about equal	3
Pretty bad	4
Very bad: could hardly be worse	5

Scoring Interpretation:

Threshold	Recommended Intervention
Pre-program score of **>3** on any question and/or a total score of **>25**	-Patients scoring >3 on any individual question or a total score >25 should be evaluated by staff. Scores from the PHQ-9 should be used to determine if the patient should be referred back to their MD for evaluation. -Survey should be re-administered at discharge to monitor progress.

Actions recommended: