# Vascular Rehabilitation Program
## *Physician Referral*

Patient Name: _____ Date of Birth: _____Phone: _____

Insurance: _____

**Vascular Rehabilitation Program**

*Clinician monitored exercise training for patients with Peripheral Artery Disease.*

*Referred to Location:*

- ☐ **Tacoma General Hospital**
  - Please fax this form to (253) 403-4386
- ☐ **Gig Harbor Medical Park**
  - Please fax this form to (253) 403-4386
- ☐ **Auburn Medical Center**
  - Please fax this form to (253) 333-2607
- ☐ **Good Samaritan Hospital – Medical Office Building**
  - Please fax this form to (253) 697-3325
- ☐ **Deaconess Hospital**
  - Please fax this form to (509) 603-2039
- ☐ **Valley Hospital**
  - Please fax this form to (509) 473-2039

**Diagnosis**

*The following are covered by Medicare for 36 sessions within 12 weeks. Other private insurances may need to be checked prior to patient enrollment. Please select one of the following:*

☐ Atherosclerosis of native arteries of extremities with intermittent claudication
☐ Right leg ☐ Left leg ☐ Bilateral legs

☐ Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication
☐ Right leg ☐ Left leg ☐ Bilateral legs

☐ Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication
☐ Right leg ☐ Left leg ☐ Bilateral legs

☐ Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication
☐ Right leg ☐ Left leg ☐ Bilateral legs

**Physician's Name: _____**

**Physician's Signature: _____ Date: _____**