ARKANSAS HEART HOSPITAL®

YOUR HEART HOSPITAL

SPECIAL PROCEDURE CONSENT

1. I hereby authorize Dr. Loyd and such assistants as may be selected by him to perform the following procedure:

EXERCISE TOLERANCE TEST
sub-maximal treadmill, bike, NuStep test, and/or 6-minute walk test

The nature and purpose of the procedure, possible alternative methods of the diagnosis, the risks involved, and the possibility of complications have been fully explained to me by Dr. Loyd and his assistants. No guarantee of assurance has been given by anyone as to the results that may be obtained.

2. I recognize that during the course of the procedure unforeseen conditions may necessitate the physician to exercise his judgment in requiring additional or different procedures than those set forth above. In view of such unforeseen conditions, I, therefore, further authorize and request that the above named doctor, his assistants or his designee perform such procedures as are, in his professional judgment, necessary and desirable.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT.

Date & Time:_____

DOB: _____

MRN:_____

_____
(Printed Patient Name)

_____
(Signature of Patient)

_____
(Signature of Witness)

Appendix 5
Form of Patient Authorization
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I will be receiving treatments using the Pritikin Intensive Cardiac Rehabilitation Program ("Pritikin Program"), and I authorize my doctors, hospital and other clinicians (together "Providers") who are providing my cardiac rehabilitation treatment to disclose to Pritikin ICR LLC and its agents, representatives and contractors (collectively "Pritikin") health related information about me as described below:

1. The health-related information that may be used and disclosed includes my complete medical record of my participation in the Pritikin Program at **Strong Hearts Cardiac Rehab**.

2. I understand and agree that Pritikin may use and disclose my health-related information to:
   - study and analyze the health outcomes of participants in the Pritikin Program.
   - provide to me by mail and/or e-mail with educational and marketing materials on products and services offered by Pritikin.

3. I understand that Pritikin WILL NOT USE MY NAME, OR ANY INFORMATION TYPICALLY USED TO IDENTIFY ME IN ANY PUBLICALLY AVAILABLE DOCUMENTS created by Pritikin in performing any study or analysis. I also understand that Pritikin will de-identify my information and/or aggregate my information with information of other patients before including any information about me in these public documents.

4. I understand that this Authorization is voluntary and that my treatment, payment for treatment or health insurance enrollment will not be affected if I refuse to sign this form. I also understand that if I do not sign this Authorization, Pritikin cannot obtain and use health related information about me and my medical condition as described in this Authorization except for information provided by the Facility under a contract between Pritikin and the Facility.

5. I understand that once my health-related information has been disclosed, federal privacy laws may no longer protect the information from further disclosure. However, Pritikin agrees to protect my information by using and disclosing it only for the purposes described above or as required by law.

6. I understand that I may change my mind and revoke (take back) this Authorization at any time in writing by sending a letter to my Providers. Revoking this Authorization will prohibit further disclosure of my health-related information by my Providers to Pritikin; however, if I revoke this Authorization Pritikin may still share any information it has already received with my Providers and use and disclose that information as described in this Authorization. Unless I revoke this Authorization, it will expire (ends) one (1) year from the date indicated below.

7. I will receive a signed copy of this Authorization to keep for my records.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Print Name of Patient or Legal Representative | Patient's Email

_____

Representative's Relationship to Patient

Duke Activity Status Index

Overview:

The Duke Activity Status Index is a self-administered questionnaire that measures a patient's functional capacity. It can be used to get a rough estimate of a patient's peak oxygen uptake.

Item	Activity	Yes	No
1	Can you take care of yourself (eating dressing bathing or using the toilet)?		
2	Can you walk indoors such as around your house?		
3	Can you walk a block or two on level ground?		
4	Can you climb a flight of stairs or walk up a hill?		
5	Can you run a short distance?		
6	Can you do light work around the house like vacuuming sweeping floors or carrying in groceries?		
7	Can you do **moderate** work around the house like scrubbing floors or lifting and moving heavy furniture?		
8	Can you do **heavy** work around the house like scrubbing floors or lifting and moving heavy furniture?		
9	Can you do yardwork like raking leaves weeding or pushing a power mower?		
10	Can you have sexual relationship?		
11	Can you participate in moderate recreational activities like golf, bowling, dancing, doubles tennis, or throwing a baseball or football?		
12	Can you participate in strenuous sports like swimming, singles tennis, football, basketball or skiing?		

Source: American College of Sports Medicine's Guidelines for Exercise Testing and Prescription, 6th Edition, 2000, pp. 175-176

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

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 figety 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	0	1	2	3
(Add Columns)			+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

TOTAL: _____

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 _____

DIETARY FAT SCREENER

Think about your eating habits over the past year or so. About how often do you eat each of the following foods? Remember breakfast, lunch, dinner, snacks, and eating out. Check a box for each food.

	0	1	2	3	4
Meals & Snacks	1/ month or less	2-3 times a month	1-2 times a week	3-4 times a week	5+ times a week
Hamburgers, ground beef, meat burritos, tacos					
Beef or pork, such as steaks, roasts, ribs, or in sandwiches					
Fried chicken					
Hot dogs, or Polish or Italian sausage					
Cold cuts, lunch meats, ham (not low-fat)					
Bacon or breakfast sausage					
Salad dressings (not low-fat)					
Margarine, butter or mayo on bread or potatoes					
Margarine, butter or oil in cooking					
Eggs (not Egg Beaters or just egg whites)					
Pizza					
Cheese, cheese spread (not low-fat)					
Whole milk					
French fries, fried potatoes					
Corn chips, potato chips, popcorn, crackers					
Doughnuts, pastries, cake, cookies (not low-fat)					
Ice cream (not sherbet or non-fat)					

STRONG HEARTS REHABILITATION CENTER

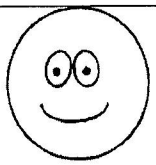
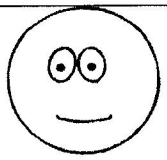
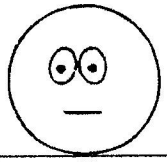
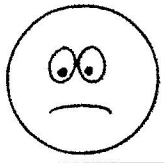
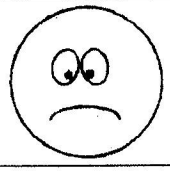
DARTMOUTH COOP QUALITY OF LIFE

Name: _____ Date: _____

Please circle the answer that best describes how you felt during the past 4 weeks.

FEELINGS

During the past 4 weeks...
How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted and blue?

Not at all	
Slightly	
Moderately	
Quite a bit	
Extremely	

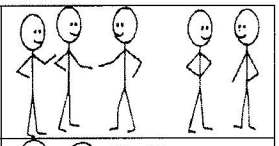
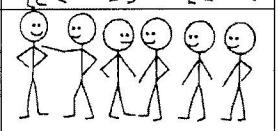
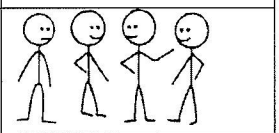
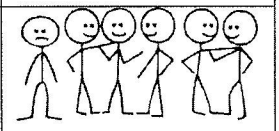
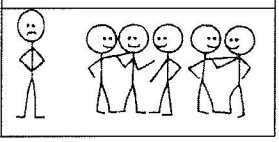
DAILY ACTIVITIES

During the past 4 weeks...
How much difficulty have you had doing your usual activities or tasks, both inside and outside the house because of your physical and emotional health?

No difficulty at all	
A little bit of difficulty	
Some difficulty	
Much difficulty	
Could not do	

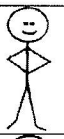
SOCIAL ACTIVITIES

During the past 4 weeks...
Has your physical and emotional health limited your social activities with family, friends, neighbors or groups?

Not at all	
Slightly	
Moderately	
Quite a bit	
Extremely	

PAIN

During the past 4 weeks...
How much bodily pain have you generally had?

No pain	
Very mild pain	
Mild pain	
Moderate pain	
Severe pain	

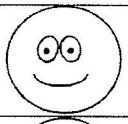
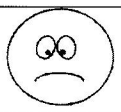
CHANGE IN HEALTH

How would you rate your overall health now compared to 4 weeks ago?

Much better	
A little better	
About the same	
A little worse	
Much worse	

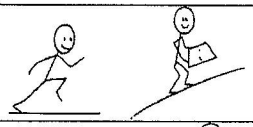
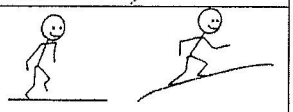
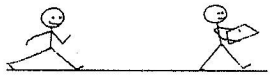
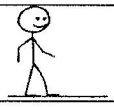
OVERALL HEALTH

During the past 4 weeks...
How would you rate your health in general?

Excellent	
Very good	
Good	
Fair	
Poor	

PHYSICAL FITNESS

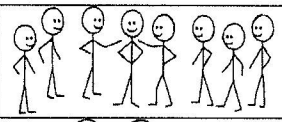
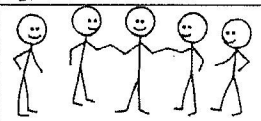
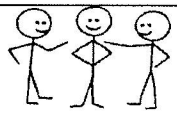
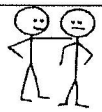
During the past 4 weeks...
What was the hardest physical activity you could do for at least 12 minutes?

Very heavy (for ex.) -- run, fast pace -- carry a heavy load upstairs or uphill (25lbs/10kgs)	
Heavy (for example) -- jog, slow pace -- carry a heavy load on level ground (25lbs/10kgs)	
Moderate (for ex.) -- walk, fast pace -- carry a heavy load on level ground (25lbs/10kgs)	
Light (for example) -- walk, medium pace -- carry light load on level ground (10lbs/10kgs)	
Very light (for ex.) -- walk, slow pace -- wash dishes	

SOCIAL SUPPORT

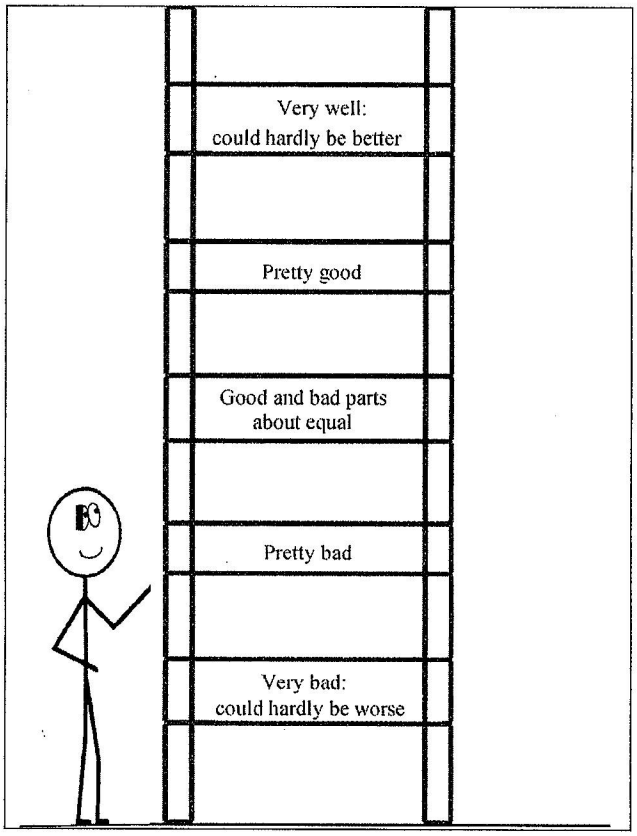
During the past 4 weeks...
Was someone available to help you if you needed and wanted help? For example, if you

- 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	
Yes, quite a bit	
Yes, some	
Yes, a little	
No, not at all	

QUALITY OF LIFE

How have things been going for you during the past 4 weeks?



TOTAL SCORE: _____

Fagerstrom Test for Nicotine Dependence (FND)

Name: _____

MRN: _____

Date of Assessment: (mm/dd/yyyy) __ __/__ __/__ __ __ __

Do you currently smoke cigarettes?

☐ No ☐ Yes

If "Yes", read each question below. For each question, enter the answer which best describes your response.

1. How soon after you wake up do you smoke your first cigarette?

☐ Within 5 minutes ☐ 31 to 60 minutes
☐ 6 to 30 minutes ☐ After 60 minutes

2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g. in church, at the library, in the cinema)?

☐ No ☐ Yes

3. Which cigarette would you hate most to give up?

☐ The first one in the morning ☐ Any other

4. How many cigarettes per day do you smoke?

☐ 10 or less ☐ 21 to 30
☐ 11 to 20 ☐ 31 to more

5. Do you smoke more frequently during the first hours after waking than during the rest of the day?

☐ No ☐ Yes

6. Do you smoke when you are so ill that you are in bed most of the day?

☐ No ☐ Yes

Comments:

Heatherton TF, Kozlowski LT Frecker RC (1991). The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. British Journal of Addiction 86: 111-27.