2617 Phillips Dr. • Jonesboro, AR 72401
(870) 932-1898 • Fax: (870) 933-9094

Cardiovascular Program Referral Form

CLIENT INFORMATION

Name:____ Age____________________

Address: ____

____

Phone Number: (   ) ____

DOB: ____

Reason for Referral: ____

Mr. / Ms._________________________________ is medically cleared for participation in the **cardiovascular** program at the NEA Clinic Wellness Center.

Any areas of concern ____

As a part of the program, we include a Health Risk Appraisal assessment of the patient's overall health. To make the best use of such a tool, we need the following clinical data:

- Blood Pressure _________ / _________
- Total Cholesterol _________ HDL _________ LDL _________
- Triglycerides _____________________
- Glucose __________________________
- Fasting __________________________
- HgbA1c _________________________

In addition, we will be checking the participant's height, weight, body composition, as well as, surveying their lifestyle habits. Each participant will receive a Personal Wellness Report. A summary report of your patient's participation and results will be sent to you if you wish. Please provide your contact information below.

Physician Name: ____

Office Address: ____

City/ST/Zip: ____

Phone: ___________________________________Fax: ____________________________________

We look forward to working closely with your patient, to help them optimize their health and attain a greater sense of "wellness" in all aspects of their life. It takes a team effort to achieve success in changing behaviors and we welcome you and your patient to our team!