



Patient Name _____	Ordering Physician Signature _____
Date of Birth _____	Social Security _____
Address _____	Ordering Physician _____
City _____	State _____ Zip _____
Telephone # _____	Primary Care Physician _____
Primary Insurance _____	Send Copy To _____
Primary Policy # _____	Fax Results To _____
Secondary Insurance _____	Diagnosis #1 _____ ICD- 10Code _____
Secondary Policy # _____	Diagnosis #2 _____ ICD-10 Code _____
Group # _____	Diagnosis #3 _____ ICD-10 Code _____
	Diagnosis #4 _____ ICD-10 Code _____

Functional Assessment Referral Form

Date of referral: _____

Six Minute Walk Test

- Heart rate and hemodynamic monitoring.
- Initiate/titrate supplemental oxygen PRN during exercise.
- Evaluation of:
 - ✓ Claudication
 - ✓ Functional Status
 - ✓ Walking Capacity

Other: _____

**PLEASE FAX COMPLETED FORM TO
574-364-2531**