**SDPI Healthy Heart Project**

**Medical clearance form**

Fort Belknap Indian Community

**Medical Clearance Form**

**SDPI Grant criteria requires all lab values, ECG, and Medical Clearance be completed within 30 days of Enrollment or Annual Assessment due date.**

**\*The due-date parameters are located on EHR under the tab “Cover Sheet”, listed under the “Crisis Alerts” heading.**

|  |  |  |
| --- | --- | --- |
| Date | | Chart Number: |
| Patients Name: | | |
| **REQUIRED LAB TESTS (within 30 days of due date)** | | **RESULTS/ DATE PERFORMED** |
| LDL – Cholesterol *(calculated )* | |  |
| LDL Direct | |  |
| HDL | |  |
| Cholesterol | |  |
| Triglycerides | |  |
| HA1C | |  |
| A/C Ratio | |  |
| **ECG** | | **Results / Dates Performed** |
| Was an ECG Performed today?  Are you recommending a stress test? | | * Yes * No Date performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Yes * No   If yes, indicate date of scheduled Stress test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **DIAGNOSIS IN ADDITION TO TYPE II DIABETES** | | |
| Does the Patient have a diagnosis of Cardiovascular Disease?  Comments: | | * No * Yes, please indicate type below:   Coronary Artery disease Y N Diagnosis date: \_\_\_\_\_\_\_  Cerebral Acicular Disease Y N Diagnosis Date:\_\_\_\_\_\_\_  Peripheral Vascular Disease Y N Diagnosis date:\_\_\_\_\_\_\_\_  Aortic Disease Y N Diagnosis Date:\_\_\_\_\_\_\_ |
| **PARTICIPATION CLEARANCE** | | |
| Does the patient have cardiac clearance to participate in a Physical Fitness program? | * Yes * No | Please indicate the following exercises the patient can participate in:   * Swimming * Walking * Aerobics * Weight lifting * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| At this time, does the medical provider performing this physical exam agree that the patient is medically stable and is therefore a good candidate for the Healthy Heart Project? | * Yes * No | If no, please state why. |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Licensed Primary Provider Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date