Conway Medical Center
Peripheral Arterial Disease Program
Supervised Exercise Therapy (SET)

2369 Cypress Circle
Conway, SC 29526
Phone: (843) 347-8153
Fax: (843) 347-1536 or (843) 234-8905

Patient Name: _____

Address: _____

_____

Phone: _____

Age: _____ Sex: _____ DOB: _____

Please check appropriate location of disease and ICD 10 code. NOTE: ALL MUST BE SYMPTOMATIC

Intermittent Pain

___ Right leg – 170.211
___ Left leg – 170.212
___ Bilateral legs – 170.213
___ Other extremity – 170.218

Bypass Grafts / Pain

___ Right Leg – 170.311
___ Left leg – 170.312
___ Bilateral legs – 170.313
___ Other extremity – 170.318

Nonbiologic Grafts w/ Pain

___ Right leg – 170.611
___ Left leg – 170.612
___ Bilateral legs – 170.613
___ Other extremity – 170.618

Atherosclerosis of Bypass Grafts w/ Pain

___ Right Leg – 170.711
___ Left leg – 170.712
___ Bilateral legs – 170.713
___ Other extremity – 170.718

Please check the program appropriate for your patient:

___ Supervised Exercise Therapy for PAD – 36 visits over a period of 12 weeks – 30 to 60 minutes per session.

___ Phase 3 – Cardiac Rehabilitation for continued PAD and CAD prevention and treatment – SELF PAY.

Please enroll my patient in the SET program for Peripheral Arterial Disease. As this patients referring physician, I can expect regular reports regarding my patient's progress.

I attest that this patient has received information regarding cardiovascular disease and PAD risk factor reduction including education, counseling, behavioral interventions, and outcomes assessments. I have seen this patient face to face and have reviewed the above risk factor management information with the patient.

_____ _____ _____
Physician Signature | Physician Name – Printed | Date

Address
_____
_____
_____

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