



Renal Services Exercise Prescription Form

Name: _____
Attending Physician: _____
Date: _____
Facility: _____

ID: _____ Gender: _____
MR#: _____
DOB: _____ Age: _____

Medical History

ESRD Cause: _____

Medical History: _____

Access: _____

Exercise Prescription

Activity level prior to Exercise Program: _____

ICD9 Code for Exercise: _____

Warm up: Duration: _____ Type: _____

CV Exercise:

Mode: _____

Intensity: _____

RPE: _____

Frequency: _____

Duration: _____

Cool down: Duration: _____ Type: _____

Weight Training: Yes ___ No ___ Type: _____

Home Program: Yes ___ No ___ Type: _____

Other Considerations:

Exercise Physiologist: _____

(Signature)

(Date)

Exercise Test Information

Date: _____

Type: _____

Test Time: _____

Weight: kg: _____ lbs: _____

Pre HR: _____

Post HR: _____

Pre BP: _____

Post BP: _____

RPE: _____

Comments: _____

Follow Up: _____