**Anmeldeformular Ambulante Kardiale Rehabilitation (AKR)**

Herr / Frau

NAME: ........................................................... GEB.DATUM: ...................................................

VORNAME: ........................................................... TEL. P: .............................. G:...............................

ADRESSE: ........................................................... WOHNORT: ..........................................................  
KR’KASSE: ........................................................... SEKTION: ............................................................

HAUSARZT: .......................................................... KARDIOLOGE: ....................................................

**Kardiale DIAGNOSE / Datum:** .................................................................................................................  
 .................................................................................................................................................................................................................................. **Weitere Diagnosen:** .................................................................................................................  
 .................................................................................................................  
 ................................................................................................................. **Probl. Bewegungsapparat:** .................................................................................................................  
 .................................................................................................................

**Kardiovaskuläre Risikofaktoren: Status / Laborwerte:**

🞎 **Nikotin** **Grösse: ..............................................**

🞎 **arterielle Hypertonie** **Gewicht: .............................................**

**🞎 Diabetes mellitus Typ I Gesamtcholesterin: ...........................**

**🞎 Diabetes mellitus Typ II LDL-Cholesterin: ...............................**

**🞎 Hyperlipidämie HDL-Cholesterin: ..............................**

**🞎 Stress familiär 🞎 beruflich 🞎 Triglyceride: ......................**................

**🞎 Adipositas m/Bewegungsmangel**

**🞎 Vererbung**

**🞎**

**Auswurffraktion** LV(EF ): ………%

**Belastungs-EKG:** Datum Watt Belastungs- Ischämie/AP Rhytm. Stör. Dauer

🞎 mit Beta-Blocker

🞎 ohne Beta-Blocker ............. ............ .................. Ja / Nein Ja / Nein

Puls Ruhe Max. Puls

................ ...............

**Medikamente** ............................................................ .................................................................... ............................................................. .................................................................... ............................................................. ....................................................................  
 ............................................................. ....................................................................

Bemerkungen: ..............................................................................................................................................

**☞ Bitte Mail (Anmeldung / Korobericht / Austrittsbericht) an:** [**physiotherapie.kso@spital.so.ch**](mailto:physiotherapie.kso@spital.so.ch) (Stempel + Unterschrift)