Central East
REGIONAL
CARDIOVASCULAR
REHAB

INFORMED CONSENT FOR CARDIOVASCULAR REHABILITATION OF PATIENTS WITH KNOWN OR SUSPECTED CARDIOVASCULAR DISEASE

Name:	Date of Birth	Today's Date
	Day Month Year	Day Month Year

The aim of the Central East Regional Cardiovascular Rehabilitation Program is to teach the skills required to lead a heart-healthy lifestyle. This program includes physical exercise, education, and counseling to improve risk factor profile and minimize the health burden of cardiovascular and metabolic conditions.

1. **Program Explanation:** I will be prescribed an exercise program and will exercise under the supervision of the program staff. I will be given instructions regarding the frequency, intensity and type of exercise I should do. I will follow these instructions to ensure I am exercising at the prescribed level. I understand that I am expected to attend every session. I agree to report any changes in health or current medications to the program staff before starting an exercise session. I agree to immediately inform staff of any pain, discomfort or other symptoms that I may have before, during or after participating in an exercise session.
2. **Risks:** I understand that there are associated risks with exercise. I may injure myself or experience fainting, abnormal blood pressure, chest discomfort, leg cramps, and in very rare instances, heart attack, stroke or even death. I understand that every effort will be made to minimize these occurrences by proper staff assessment of my condition before, during and after each exercise session. I have been informed that trained staff, emergency equipment and supplies are readily available to manage unusual situations should they occur.
3. **Confidentiality and Use of Information:** Information collected about your health and the care you receive will be stored on a secured web-based computer system – some may also be stored in paper form in clinical or hospital charts. This information is used to better understand patient needs and improve the care provided. The information will be stored in a computer system that is compliant with the provincial privacy legislation and access is restricted to staff of the Central East Regional Cardiovascular Rehabilitation Program connected to services you receive. This information is confidential. I give permission for medical information concerning my condition to be obtained from or transmitted to my treating physician(s).
4. **Future Research:** I agree to the use of any information for research and statistical purposes as long as the same does not identify my person or provide facts that could lead to my identification.
5. If we would like to do specific research such as clinical trials in the future, may we contact you?

❐ YES ❐ NO

Informed Consent Statement

I have read this form in its entirety and any questions I have asked have been answered to my satisfaction. ***I agree to participate in the Central East Regional Cardiovascular Rehabilitation Program.***

Signature of Patient / SDM

If using a Substitute **Decision Maker (SDM)**

Print Name of SDM

If signed by SDM, state relationship to patient