GRAND MEDICAL CENTRE

Community Health Centre

Cardiac Rehabilitation Program Referral

The Cardiac Rehabilitation program is a 12 week community-based cardiovascular prevention and rehabilitation program consisting of education and exercise 1x/week.

REFERRAL DATE: ___ ___ ___ M D Y	DATE OF BIRTH: ___ ___ ___ M D Y	OHIP#

SURNAME:	FIRST NAME:	TEL:
ADDRESS:	CITY:	POSTAL CODE:

REFERRAL SOURCE	NAME:	ADDRESS:
	TEL:	FAX:

PRIMARY CARE PROVIDER (if different than above)	NAME:	TEL:	FAX:

This patient is being referred for a comprehensive cardiovascular rehabilitation program including medical consultation, cardiopulmonary stress test, exercise intervention and access to dietitican and social worker.

Cardiac History: (YY / MM / DD)

Myocardial infarction (MI) _____/_____/_____
Angioplasty (PCI) _____/_____/_____
History of congestive heart failure _____/_____/_____
Bypass surgery (ACB) _____/_____/_____
Atrial Fibrillation _____/_____/_____
Ablation/Cardioversion _____/_____/_____
Myocarditis _____/_____/_____
Aortic Aneurysm _____/_____/_____

Pacemaker / ICD _____/_____/_____
Angina _____/_____/_____
PVD _____/_____/_____
Valve _____/_____/_____
Cardiomyopathy _____/_____/_____
Pericarditis _____/_____/_____
SCAD _____/_____/_____
Other: _____ _____/_____/_____

OTHER RISK FACTORS (Please check if present)

☐ Smoking ☐ Hypertension ☐ Dyslipidemia ☐ Diabetes ☐ Obesity ☐ Stress ☐ Depression ☐ Inactivity
☐ Family History ☐ PVD

Most recent cardiac-related hospitalization or transfer date: (YY/ MM / DD) _____/_____/_____
Hospital:_____
Reason:_____

Please Include: (a) A recent complete history (b) Echo results (if available) and (c) Recent blood work (d) A recent 12 lead ECG (e) Stress test results (if available) (f) Angiogram results (g) Procedure results

PHYSICIAN or NP's CLEARANCE TO PARTICIPATE IN EXERCISE

To ensure client safety for graded levels of exercise, please indicate below if client is **medically stable and cleared to participate in mild to moderate exercise**

☐ YES, client is medically stable and **can participate** in exercise
☐ NO, client **cannot participate** in exercise

Physician / Nurse Practitioner / Delegate Signature:

Fax signed and completed form to: **226-227-1437**

Ontario
Hamilton Niagara Haldimand Brant Local Health Integration Network
Réseau local d'intégration des services de santé de Hamilton Niagara Haldimand Brant