TotalCardiology®
Your Heart. Your Health. For Life.
Rehabilitation

REFERRAL FORM

PATIENT INFORMATION:

Name:					
AHC #:		**DOB (day/month/year):**			
Street Address:					
City:		**Province:**		**Postal Code:**	
Home #:		**Cell #:**		**Work #:**	
Referring MD:		**Family MD:**		**Primary Cardiologist:**	

Medical History:

- ☐ Coronary Artery Disease
- ☐ Congenital Heart Clinic Patient
- ☐ Heart Surgery
- ☐ Heart Failure (EF < 40%)
- ☐ Angioplasty/PCI
- ☐ Heart Transplant (pre/post)
- ☐ Thoracic Aortic Surgery
- ☐ STEMI
  - O Early Cardiac Access
  - O Smoking Cessation
- ☐ ACS

Patient resides in AHS – Calgary Zone: ☐ Yes ☐ No If no, name of AHS zone:

Other Relevant Information (e.g. communication barriers, clinical information):

IN ORDER TO PROCESS THIS REFERRAL, PLEASE ENSURE ALL ABOVE FIELDS ARE COMPLETED

The TotalCardiology Rehabilitation program is a 12-week cardiac rehabilitation program and includes exercise stress testing at initial appointment, 12-week (completion of exercise program), 1-year and 2-year follow-up appointments. Patients qualify once, unless they have a recurrent cardiac event.

_____
Referring Physician Signature

_____
Please print Physician Name

_____
Hospital Order MD Name / RN
(No MD Signature required)

_____ _____
Date **Phone Number**

Physician name and address:

ULI# _____