TotalCardiology®

Rehabilitation

REFERRAL FORM

Office Use Only. Place patient label here.

PATIENT INFORMATION AND MEDICAL HISTORY

Name: ______________________

AHC #: ______________ **DOB (day/month/year):** ______________

Street Address: ______________________

City: ________ **Province:** ________ **Postal Code:** ________

Home #: ________ **Cell #:** ________ **Work #:** ________

Referring MD: ________ **Family MD:** ________ **Cardiologist/Surgeon:** ________

CARDIAC REHABILITATION PROGRAM

- ☐ CAD
  - ☐ Angioplasty/PCI
  - ☐ Medical management
- ☐ ACS
  - ☐ STEMI/NSTEMI
  - ☐ Unstable angina/Stable angina
- ☐ Heart surgery
  - ☐ CABG
  - ☐ Valve
- ☐ Heart failure with reduced EF (< 40%)
  - ☐ Cardiac amyloidosis
- ☐ Thoracic aortic surgery
- ☐ Heart transplant (pre/post)
- ☐ Other (*please describe*):

MEDICALLY SUPERVISED EXERCISE PROGRAM

- ☐ Left ventricular assist device (LVAD)
- ☐ Peripheral artery disease (PAD):
  - ☐ Medically managed
  - ☐ Revascularization
- ☐ Postural orthostatic tachycardia syndrome (POTS)
- ☐ Other *(please describe):*

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.**
PLEASE INCLUDE FACE SHEET AND DISCHARGE SUMMARY IF APPLICABLE*

The cardiac rehabilitation and medically-supervised exercise programs include exercise stress testing (EST). Depending on patient stream and medical history, EST may occur at initial, 12-week (exercise completion), 1-year and 2-year follow-up appointments. Patients qualify once unless recurrent event.

____
Referring Physician Signature

____
Please Print Name

____
Hospital Order MD Name / RN *(no signature required)*

__________ __________
Date **Phone**

Physician Name and Address:

Prac ID: