TotalCardiology®
Your Heart. Your Health. For Life.
Risk Reduction

HEART HEALTH ASSESSMENT
PHYSICIAN REFERRAL FORM

PATIENT INFORMATION:

Date:	**Name:**	
Street Address: **City:** **Province:** **Postal Code:**		**Home Phone:** **Work:** **Cell:**
AHC#:	**DOB (d/m/yy):**	**Hospital #:**
Other Health Insurance:		

❒ I am referring my patient to the *Heart Health Program* for people who have been screened and found to have four or more of the following major risk factors, but do not necessarily have heart disease. This program consists of a half-day of assessments and counseling to reduce cardiovascular risk.

❒	Male over 45	❒	Smoking
❒	Female over 55	❒	Family History of Heart Disease
❒	Male Gender	❒	Diabetes
❒	Hypertension	❒	Sedentary Lifestyle
❒	Abnormal Lipid Profile	❒	Obesity

Referring Physician Signature

Physician Name (please print)

Date **Phone Number**

Physician name and address:

ULI# _____

***PLEASE RETURN THIS FORM ALONG WITH THE FOLLOWING REPORTS:**

- EKG, blood tests
- Surgical Reports
- History
- Any other tests of relevant information

TotalCardiology Risk Reduction requires the above relevant cardiac history information to process this referral.

PATIENT RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize my referring physician and/or hospital to release to TotalCardiology Rehabilitation and Risk Reduction Centre:

❒ Confirmation of Hospitalization Dates ❒ All ❒ Most Recent ❒ Specific Date(s): _____

❒ ER/Outpatient Info Date: _____

❒ Inpatient Info Admission Date: _____

❒ Entire Record ❒ Specific Documents: _____

Patient signature | Printed Name | Date