



PATIENT INFORMATION:						
<b>Name:</b>						
<b>AHC #:</b>		<b>DOB (day/month/year):</b>				
<b>Street Address:</b>						
<b>City:</b>		<b>Province:</b>		<b>Postal Code:</b>		
<b>Home #:</b>		<b>Cell #:</b>		<b>Work #:</b>		
<b>Referring MD:</b>			<b>Family MD:</b>		<b>Primary Cardiologist:</b>	
<b>Medical History:</b>						
<input type="checkbox"/> Coronary Artery Disease		<input type="checkbox"/> Angioplasty/PCI		<input type="checkbox"/> STEMI		
<input type="checkbox"/> Congenital Heart Clinic Patient		<input type="checkbox"/> Heart Transplant (pre/post)		<input checked="" type="radio"/> Early Cardiac Access		
<input type="checkbox"/> Heart Surgery		<input type="checkbox"/> Thoracic Aortic Surgery		<input checked="" type="radio"/> Smoking Cessation		
<input type="checkbox"/> Heart Failure (EF < 40%)				<input type="checkbox"/> ACS		
<b>Patient resides in AHS – Calgary Zone:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, name of AHS zone:						
<b>Other Relevant Information (e.g. communication barriers, clinical information):</b>						
<b>*IN ORDER TO PROCESS THIS REFERRAL, PLEASE ENSURE ALL ABOVE FIELDS ARE COMPLETED*</b>						
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.						

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**Referring Physician Signature**

\_\_\_\_\_  
**Please print Physician Name**

\_\_\_\_\_  
**Hospital Order MD Name / RN**  
*(No MD Signature required)*

\_\_\_\_\_ **Date**                      \_\_\_\_\_ **Phone Number**

Physician name and address:

  
  

ULI# \_\_\_\_\_