Total Cardiology®
Your Heart. Your Health. For Life.

Rehabilitation

REFERRAL FORM

OFFICE USE ONLY PATIENT LABEL

PATIENT INFORMATION:

Name:

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

Street Address:

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

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

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

MEDICAL HISTORY:

Cardiac Rehabilitation Program

- ☐ CAD:
  - ☐ Angioplasty/PCI
  - ☐ Medical management
- ☐ ACS:
  - ☐ STEMI/NSTEMI
  - ☐ Unstable angina/Stable angina
- ☐ Heart surgery:
  - ☐ CABG
  - ☐ Valve surgery
- ☐ Heart failure with reduced EF (< 40%)
- ☐ 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 appointment, 12-week (completion of exercise program), 1-year and 2-year follow-up appointments. Patients qualify once, unless they have a recurrent event.

Referring Physician Signature

Please Print Name

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

Date **Phone Number**

Physician Name and Address:

Prac ID: