



Cardiac Wellness Institute of Calgary Inc.

**CARDIAC REHABILITATION PROGRAM
REFERRAL FORM**

Date:		Name:			
Street Address:			Home Phone:		
City:	Province:	Postal Code:	Work:	Cell:	
AHC#:	DOB (d/m/y):		Hospital #	FMC	
				RGH	
				PLC	
Referring MD:		Family MD:		Primary Cardiologist:	

CARDIAC WELLNESS PROGRAM for individuals with *diagnosed heart disease* as defined below is a 12-week cardiac rehabilitation program consists of cardiovascular assessments, exercise stress testing, supervised exercise and a comprehensive program of lifestyle education and counseling.

Please indicate conditions which apply to your patient:

- | | | |
|-------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> STEMI | <input type="checkbox"/> POBA | <input type="checkbox"/> Heart Valve Repair |
| <input type="checkbox"/> NSTEMI | <input type="checkbox"/> Bare Metal Stent | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> Unstable Angina | <input type="checkbox"/> Drug Eluding Stent | <input type="checkbox"/> Adult Congenital Heart Disease |
| <input type="checkbox"/> CABG x ____ | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Cardiomyopathy |
| <input type="checkbox"/> Other _____ | | |

Referring Physician Signature

Date

Phone Number

Please print Physician Name

Physician name and address
ULI#

Hospital Order MD Name/ RN (No MD signature required)

**** Please return this form along with the following reports****

- | | |
|-----------------------------|----------------------------------------------------|
| • History/Admission Notes | • Cardiac related Operative Records |
| • Discharge Summary | • ECG (most recent-one only), Lipids and Troponins |
| • Angio/POBA/Stent Reports | • Any other test results or relevant information |
| • Cardiology Clinic Letters | (i.e., Thallium, Echo, MUGA, Holter, etc) |

The Cardiac Wellness Institute requires the above relevant cardiac history information to process this referral.

PATIENT RELEASE OF INFORMATION AUTHORIZATION

I HEREBY AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO CARDIAC WELLNESS INSTITUTE BY MY PHYSICIANS AND/OR THE HOSPITAL. IF I LIVE OUTSIDE OF THE JURISDICTION OF THE CALGARY HEALTH REGION, MY REFERRAL AND RECORDS WILL BE FORWARDED TO THE CARDIAC REHABILITATION PROGRAM IN ALBERTA NEAREST TO MY HOME. IF I DO NOT QUALIFY FOR THIS PROGRAM, I AUTHORIZE THIS REFERRAL TO BE SENT TO AN APPROPRIATE PROGRAM WITHIN THE CALGARY HEALTH REGION (IE .LIVING WELL, DIABETES HYPERTENSION AND CHOLESTEROL CENTRE, ETC WHERE APPROPRIATE)

* Please read the Cardiac Wellness Institute Brochure prior to signing this form. *

X _____ **Patient Signature**

X _____ **Printed Name**