CARDIAC PREVENTION OR REHAB
REFERRAL FORM

Please complete this form in block capitals in black ink.

HEART HEALTH CENTER - 87 Front-Entry off of Chancery Lane • 441-232-2673

Patient Name	Last	First	Date of Birth	(M / F)
Insurance	Company	Policy #	Group #	
Address				
Telephone	Home	Work	Cell	Other
(Please select one)	❑ Prevention	❑ Rehabilitation	❑ Elective/Ambulatory	❑ Other / Comments

Referring MD (primary)		Tel/Cell#	
Practice		Other relevant details	

CARDIAC HISTORY

MI	Date:			Arrhythmias	
Angioplasty / stent	Date:			Current Dyspnoea	
CABG	Date:			Other events	
Heart failure	ICD	Pacemaker			
Curremt Angina	at rest	on exertion	GTN		

CURRENT STATUS - CHD RISK FACTORS

❑ Resting BP	❑ Resting Heart	❑ BMI	❑ Stable Type1/Type2 diabetes
❑ Raised Cholesterol	❑ Physically inactive	❑ Smoker	❑ Excess Alcohol
❑ Stress	❑ Family History	❑ Hyerlipademia	❑ Other

MEDICATIONS

❑ Asprin / Clopidogrel	❑ Beta Blocker	❑ Ace Inhibitor	❑ Statins
❑ Warfarin (Coumadin)	❑ Diuretic	❑ Nitrate	❑ Anti-arrhythmic
❑ Calcium Channel Blocker	❑ GTN	Other	

Patient Past Medical History, if applicable, please provide dates and details as far as possible

❑ COAD / Asthman	❑ Hypertension	❑ Epilepsy	❑ Claudation
CVA/Neuro problems		Ortho / musc skeletal problems	

PLEASE SEND REFERRAL WITH MOST RECENT BLOOD WORK

Referrer's Signature	Date
Comments:	

Important Notice:
The patient exhibits no contradiction to exercise (see below)

❑ The patient is clinically stable ❑ The patient is compliant with medication
❑ The patient is awaitinh / not awaiting further medical or surgical treatment

Referrers Signature_____

Print Name_____Date_____

Patient Informed Consent:
I agree for the above information to be passed onto C.O.R.E personel. I understand that I am responsible for monitoring my own responses during exercise and will inform the instructor of any new or unusual symptoms. I will also inform the instructor in any changes in medication, the results of any investigations or treatment.

Patient Sign_____

Print Name_____Date_____