Maitland Valley
Family Health Team

# Cardiac Rehabilitation Program

| | | |
|---|---|---|
| Date of Referral: | | |
| Patient Name: Son Pss | | TEL: Home: |
| Address: | | Work: |
| City: | Postal Code: | Cell: |
| DOB: | HC #: | Version Code: |

## Referring Physician Information

| | |
|---|---|
| Name: | |
| Address: | |
| Phone: | FAX: |

## Reason for Referral *(select all applicable)*

- ☐ Acute Coronary Syndrome
- ☐ Chronic Stable Angina
- ☐ Chronic Stable Heart Failure
- ☐ Coronary Artery Bypass
- ☐ Cardiac Valve Surgery
- ☐ Percutaneous Coronary or Valvular Intervention
- ☐ Other

| Risk Factors | Lifestyle Factors | Barriers |
|---|---|---|
| ☐ Hypertension | ☐ Smoking | ☐ Transportation |
| ☐ Dyslipidemia | ☐ Obesity | ☐ Financial |
| ☐ Diabetes | ☐ High Stress | ☐ Attitudinal |
| ☐ Arrhythmia | ☐ Untreated Depression/Anxiety | ☐ Interpersonal/Lack Supports |
| | ☐ Poor Exercise Tolerance | ☐ Literacy Issues |

## Relevant Tests/Reports

- ☐ Exercise Stress Test w/ Exercise Rx
- ☐ Angio Report
- ☐ CABG OR Report
- ☐ Echo (most recent)
- ☐ MIBI
- ☐ Recent Blood Work

## Miscellaneous

Occupation: Expected Date of Return:

**Social Support Network**

Married: ☐ Yes ☐ No Spouse's Name:

Other Supports:

Are there any orthopaedic problems or other problems that might impair the ability to exercise?

If yes:

## Comments

Signature

Date