Community Cardiovascular
Hearts in Motion

PATIENT REFERRAL FORM

Phone: 473-3744
Fax: 473-3338

Please check one : □ Spryfield site □ Dartmouth site □ Lower Sackville site

Patient _____DOB (Y/M/D) _____ Health Card#_____
Address _____
Telephone (H) _____(W) _____(Cell)_____

The following section must be completed for entry to program **Patient is aware of referral: □ Yes □ No**

ENTRANCE CRITERIA

Please see exclusion criteria on the back of referral from to ensure patient is appropriate to attend CCHIM

Patients must have ***at least one*** of the following ***highlighted criteria*** in order to participate in the program. Please check all that apply:

□ **Established Vascular Disease**
- □ Coronary artery disease
- □ Peripheral vascular disease
- □ Cerebral vascular disease (non-disabling stroke or TIA)
- □ Atherosclerotic Renal Vascular Disease

□ **Diabetes + 1 of the following Risk Factors**
- □ Smoking
- □ Hypertension
- □ Dyslipidemia

□ **3 or more Risk Factors**
- □ Smoking
- □ Hypertension
- □ Dyslipidemia
- □ Pre-Diabetes (fasting glucose > 6.1)

□ **Atrial Fibrillation:**
- □ Poorly controlled Afib (poor rate control or difficulty with anticoagulation control)
- □ Afib with one risk factor (as previously described) or with established vascular disease

***If available, please include copies of cath reports, most recent exercise stress test, hospital discharge summary and pertinent consultation letters.**

Lipid Profile: TG:_____ TChol:_____ LDL:_____ HDL:_____ TC/HDL Ratio_____
Fasting Glucose:_____ BP_____ A1c_____ EF%(if available)_____

Special Considerations (Ex. Orthopedic limitations, cognitive or hearing impairments):
_____
_____
_____
_____

Referring Physician (Print or Stamp):