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PATIENT LABEL

CARDIOVASCULAR PREVENTION & REHABILITATION PROGRAM REFERRAL
Fax to: 705-434-5118

| | |
|-----------------|------------------------|
| Name: | |
| Address: | |
| Phone: | DOB: (dd/mm/yy) |

Indication for Referral: MI Valve PCI TIA/Stroke
 CABG Angina CHF Dysrhythmia PVD

Risk Factors: Diabetes Hypertension Dyslipidemia
 Smoker Obesity Stress Family Hx

Medical History:

Allergies:

Surgical Procedures:

Medication:

Recent Prior investigations (attach results):

| | |
|---|--|
| <input type="checkbox"/> ECG | <input type="checkbox"/> Angiogram report |
| <input type="checkbox"/> Stress test | <input type="checkbox"/> Lipid Profile (last 3 months) |
| <input type="checkbox"/> Consult notes | <input type="checkbox"/> Chest X-ray |
| <input type="checkbox"/> Echocardiogram | |

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Patients referred to SMH Cardiac rehabilitation program will be assessed and treated by members of a multidisciplinary team. Team members include: Physician, Dietitian, Registered Nurse, and Registered Kinesiologist.

| | |
|-----------------------------|--|
| Physician Name: | |
| Physician Signature: | Date: (dd/mm/yy) ____/____/____ |

