

**REFERRAL**
**A. PATIENT IDENTIFICATION**

LAST NAME	FIRST NAME	INITIAL	BIRTH DAY/MONTH/YEAR	GENDER
ADDRESS		POSTAL CODE	PERSONAL HEALTH # / ULI#	
RESIDENCE TELEPHONE	BUSINESS TELEPHONE		CONTACT PERSON AND PHONE #	

**B. LANGUAGE BARRIERS**    NO    YES    FAMILY AVAILABLE / TRANSLATOR REQUIRED

**C. CURRENT EVENT**

<input type="checkbox"/>	STEMI	Date	Hospital
<input type="checkbox"/>	NSTEMI	Date	Hospital
<input type="checkbox"/>	PCI	Date	Hospital
<input type="checkbox"/>	CABG	Date	Hospital
<input type="checkbox"/>	HEART FAILURE	Date	Hospital
<input type="checkbox"/>	VALVE SURGERY	Date	Hospital
<input type="checkbox"/>	ANGINA	Date	Hospital
<input type="checkbox"/>	AICD	Date	Hospital
<input type="checkbox"/>	OTHER HEART DISEASE	Date	Hospital
COMMENTS:			

**D. RETURN TO WORK:**    Occupation \_\_\_\_\_     Retired

 ASAP or Expected Date \_\_\_\_\_     EXTENDED LEAVE

**E. CARDIOVASCULAR RISK FACTORS**

Non-Modifiable Risk Factors: <input type="checkbox"/> Heredity <input type="checkbox"/> Age <input type="checkbox"/> Male		
Modifiable Risk Factors:		
<input type="checkbox"/> SMOKING	<input type="checkbox"/> No <input type="checkbox"/> Yes	# Years:    Quit date:
<input type="checkbox"/> HYPERLIPIDEMIA <input type="checkbox"/> No <input type="checkbox"/> Yes		
<input type="checkbox"/> OBESITY    BMI <input type="checkbox"/> >25 <input type="checkbox"/> >30    Waist Circumference <input type="checkbox"/> > 102cm (m) <input type="checkbox"/> >88cm (f)		
<input type="checkbox"/> PHYSICAL INACTIVITY <input type="checkbox"/> Sedentary <input type="checkbox"/> Moderately active <input type="checkbox"/> Very active		
<input type="checkbox"/> STRESS <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> HADs score:		
<input type="checkbox"/> DIABETES <input type="checkbox"/> New onset <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> HgbA <sub>1c</sub> >7.0 <input type="checkbox"/> FBG >6.0		
<input type="checkbox"/> HYPERTENSION <input type="checkbox"/> BP>140/90 (non diabetic) <input type="checkbox"/> BP >130/80 (diabetic)		
REFERRING PHYSICIAN/PRIMARY CARE NETWORK/	ULI#	Physician to follow patient
Signature	Date:	Telephone #
GP/PCN/ any others to receive report		
OFFICE USE ONLY	NEW ADMISSION _____	DATE RECEIVED & WAITLISTED & INFORMATION MAILED AND INITIALS
	REPEAT ADMISSION _____	HOSPITAL ID#
PROGRAM PHYSICIAN	PROGRAM NURSE	ORIENTATION DATE
OTHER COMMENTS		