

Online Cardiac Rehabilitation Clinic, providing support for individuals at risk for or with cardiovascular disease. Delivered by qualified cardiac professionals.

Phone: 250-769-1334 • Fax: 778-797-0734
Email: office@pulsecardiachealth.com
Web: pulsecardiachealth.com

1 PATIENT INFORMATION

First Name: _____ Last Name: _____ Male Female
Cell Phone: _____ DOB (dd/mm/yyyy): _____
Alternate Phone: _____ Email: _____

2 REASON(S) FOR REFERRAL

- | | |
|---|---|
| <input type="radio"/> Coronary Artery Disease (Angina, MI, CABG, PCI) | <input type="radio"/> Cerebral Vascular Disease (Stroke/TIA) |
| <input type="radio"/> Valve Disease (AS, MR, Other) | <input type="radio"/> Diabetes |
| <input type="radio"/> Heart Failure | <input type="radio"/> Weight Management (Obesity) |
| <input type="radio"/> Afib/Flutter | <input type="radio"/> Primary Prevention (Risk Factors For CVD) |
| <input type="radio"/> PVD | |

3 MEDICAL CLEARANCE

Is the Patient is medically cleared to participate in a regular physical exercise program? Yes No

4 DETAILS OF REFERRAL

Please provide relevant medical history, risk factors, co-morbidities, current medications, blood lipid profile, A1C

5 REFERRING PHYSICIAN CONTACT INFORMATION

Name: _____ Clinic Name: _____
Phone: _____ Fax: _____ Email: _____

6 SIGNATURE OF REFERRING PHYSICIAN

X _____ Date (dd/mm/yyyy): _____