Pulse Cardiac Health

REFERRAL FORM

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): _____

Medical Number (PHN): _____ Email: _____

2 REASON(S) FOR REFERRAL

- ◯ Coronary Artery Disease (Angina, MI, CABG, PCI)
- ◯ Valve Disease (AS, MR, Other)
- ◯ Heart Failure
- ◯ Afib/Flutter
- ◯ PVD
- ◯ Cerebral Vascular Disease (Stroke/TIA)
- ◯ Diabetes
- ◯ Weight Management (Obesity)
- ◯ Primary Prevention (Risk Factors For CVD)

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): _____