niagarahealth

Cardiovascular Health and Rehabilitation Program

TELEPHONE: 905-641-2542 FAX: 905-704-4756

Name: _____
Last Name First Name Mr./Mrs. /Miss/Ms

Address: _____

Telephone Number: ( ) _____

Hospital ID Number: _____ HCN _____

Family Physician: _____ VC

RISK FACTORS **(Please check if present)**

1. Smoking ☐ 2. Hypertension ☐ 3. Dyslipidemia ☐ 4. Diabetes type 1 ☐ type 2 ☐

5. Overweight ☐ 6. Stress ☐ 7. Depression ☐ 8. Inactivity ☐ 9. Family History ☐

REFERRING DIAGNOSIS **(Check all that apply)**

☐ **Post MI:** Date: _____ ☐ **PTCA:** Date: _____ ☐ **CHF** ☐ **STABLE CAD**

☐ **Cardiac Surgery:** Date: _____ ☐CABG ☐Valve ☐Other:_____

☐ **Other:** _____

LV Function: ☐> 50% ☐35-49% ☐20-34% ☐Less than 20% **CCS Angina Class**: 0 I II III IV

MEDICATIONS **(Name Dose Frequency)**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

COMORBIDITIES/CONCERNS/RESTRICTIONS

☐ Angina ☐ Peripheral Vascular Disease ☐ CHF ☐ ICD ☐ Pacemaker

☐ Other:_____

_____

_____

****Referral must include a copy of most recent** **(Please check if present)**:

- ❑ Exercise stress test Date: _____ Location: _____ Tested on Beta-Blocker? ☐Yes ☐No
- ❑ Lipids and fasting glucose Date: _____

If not included your office may be contacted to arrange testing

Physician Name: _____ Telephone: _____

Signature: _____ Date:_____