



Cardiac Rehabilitation Referral Form

Date: _____

Re:	Name:		
Address:			
National ID#:	Hospital No:	Gender:	M F
Tel # Home:	Work:	Cell:	

Dear Cardiac Rehabilitation Programme Director,

Dr. _____ (*Consultant*) requests that you enroll the above-named patient in Phase II cardiac rehabilitation. The patient's cardiologist is Dr. _____.

The patient's diagnosis is _____ (*please see overleaf for a list of qualifying diagnoses. Please note that cardiac rehabilitation is useful for other diagnostic states, but details should be given*). The patient was admitted to hospital/ seen in the clinic on _____ (*date*).

ECG showed _____

Lipid profile: Total cholesterol _____ HDL _____ Triglycerides _____ LDL _____

HBA1C _____ (*if relevant*).

Echocardiogram showed: _____ (*If no echocardiogram available, please indicate*). Stress test result: Exercise time: _____. METs achieved: _____. Max HR achieved: _____ bpm. Symptoms: _____. ST changes and arrhythmias: _____. Stress test conclusion _____.

Coronary angiogram result _____

Surgery or percutaneous procedure performed: _____ Date: _____

Follow-up plan: _____

Precautions: _____

Further details of medical conditions are given overleaf.

Thank you for your assistance with management of this patient.

Signed: _____ (Print Name) _____
 (HO/SHO/Registrar/Consultant)

Phases of Cardiac Rehabilitation:

Phase	Duration	Components
I (Inpatient, immediately post event)	2 to 5 days	Physiotherapy, Dietary counselling, Smoking cessation counselling, Education
II & III (Outpatient)	12 to 36 sessions over a period of 4 to 12 weeks	Rehab nurse/Doctor's assessments Nutritionist appointments Education and counselling Supervised exercise rehabilitation
IV (Maintenance)	Lifelong	Exercise and lifestyle management (home/community based)

<i>Conditions Currently Under Medical Care</i>	<i>Physician</i>	<i>Next Appt.</i>
Qualifying Diagnosis for Cardiac Rehab		
<input type="checkbox"/> post acute myocardial infarction <input type="checkbox"/> stable angina <input type="checkbox"/> chronic heart failure <input type="checkbox"/> valve surgery <input type="checkbox"/> coronary artery bypass (CABG) <input type="checkbox"/> coronary angioplasty/stent (PTCA) <input type="checkbox"/> heart transplant other _____		
Additional Cardiac/Vascular Diagnoses		
<input type="checkbox"/> hypertension <input type="checkbox"/> dyslipidemia <input type="checkbox"/> heart failure <input type="checkbox"/> peripheral arterial disease (PAD) Other: 1. _____ 2. _____		
Other Medical Diagnoses under Treatment		
<input type="checkbox"/> diabetes mellitus, <input type="checkbox"/> type I <input type="checkbox"/> type II <input type="checkbox"/> arthritis, location _____ <input type="checkbox"/> clinical depression Other: 1. _____ 2. _____		
Significant Surgeries/Procedures in the Past		
<input type="checkbox"/> See cardiac surgeries listed above Other: 1. _____ 2. _____		