DO NOT WRITE
IN THIS SPACE

Northern Alberta Cardiac Rehabilitation Program
Glenrose Rehabilitation Hospital
10230 – 111 Avenue, Edmonton, AB T5G 0B7
Office: 780- 735-8206 Fax: 780-735-8243

For Office Use Only

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

	STEMI	Date	Hospital
	NSTEMI	Date	Hospital
	PCI	Date	Hospital
	CABG	Date	Hospital
	HEART FAILURE	Date	Hospital
	VALVE SURGERY	Date	Hospital
	ANGINA	Date	Hospital
	AICD	Date	Hospital
	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: ☐ Heredity ☐ Age ☐ Male

Modifiable Risk Factors:

☐ SMOKING ☐ No ☐ Yes # Years: Quit date:

☐ HYPERLIPIDEMIA ☐ No ☐ Yes

☐ OBESITY BMI ☐ >25 ☐ >30 Waist Circumference ☐ > 102cm (m) ☐ >88cm (f)

☐ PHYSICAL INACTIVITY ☐ Sedentary ☐ Moderately active ☐ Very active

☐ STRESS ☐ Anxiety ☐ Depression ☐ HADs score:

☐ DIABETES ☐ New onset ☐ Type I ☐ Type II ☐ $HgbA_1C$ >7.0 ☐ FBG >6.0

☐ HYPERTENSION ☐ BP>140/90 (non diabetic) ☐ 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** _____ **REPEAT ADMISSION**	DATE RECEIVED & WAITLISTED & INFORMATION MAILED AND INITIALS	HOSPITAL ID#

PROGRAM PHYSICIAN	PROGRAM NURSE	ORIENTATION DATE	**OTHER COMMENTS**