ST VINCENT'S HOSPITAL HEART HEALTH

CARDIAC REHABILITATION REFERRAL FORM

Date of referral: _____

Client details (affix sticker if available)

Name:	
Address:	
DOB:	Age:
Ph:	Mob:
Email:	
Medicare No:	
Private Health Fund	Number:

GP (Name, address, phone, fax)

_____

_____

Cardiologist (Name, address, phone, fax)

_____

_____

Marital status:

Next of Kin: Name _____ Phone _____

Interpreter required: Yes No Language required: _____

Social status: _____

Aboriginal or Torres Strait Islander: Yes No

Employment status / Occupation: _____

Reasons for referral

Cardiac diagnosis: _____

Cardiac risk factors:

Smoker ☐	High cholesterol ☐	Hypertension ☐	Overweight ☐	Depression ☐
Ex smoker ☐	Family history ☐	Diabetes ☐	Inactivity ☐	Social isolation ☐

Cardiac investigations: (attach reports if available)

_____

_____

_____

Ejection fraction: _____

Relevant medical history

_____

_____

_____

_____

_____

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