UnitingCare Health

ST STEPHEN'S HOSPITAL

Family Name: _____ MR/UR: _____

Given names: _____

Address: _____

Postcode: _____ DOB: _____

Doctor: _____

(or place Patient Identification Label here)

Referral Request Cardiac Rehab Phase II

Doctor Referring: **Date of Referral:** _____/_____/_____

Provider No.: _____

Cardiologist: _____ **Phone:** _____

Email: _____ **Fax:** _____

Address: _____

_____

Reason for Referral:

☐ CABG	☐ PPM /ICD	☐ Valve Surgery	☐ CCF/CAD medical Mx
☐ PCI	☐ Valvuloplasty	☐ Angina	☐ AMI

Date of Procedure: _____/_____/_____ **Date of Discharge:** _____/_____/_____

Investigations: (ATTACH REPORTS)

☐ Echocardiogram	☐ Angiogram	☐ Stress Test

Risk Factors:

☐ Family History	☐ Overweight	☐ High Cholesterol
☐ Hypertension	☐ Diabetes	☐ ETOH
☐ Inactivity	☐ Stress	☐ Smoker
☐ Ex-smoker	Ceased:	

Other Complications: (E.G. AF, FALLS, COGNITION, COMMENTS)

Medications on Discharge:

Health Professional Completing Referral: _____ **DATE:** ____ / ____ / ____

Signature: _____ **Contact No:** _____

ST STEPHENS HOSPITAL
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