Send referrals to

07 4124 7710 or ssh.dayrehab@uchealth.com.au

ST STEPHEN'S HOSPITAL

Referral Request Cardiac Rehab Phase II

Family Name:	MR/UR
Given Names:	Date of Birth: / /
Address:	Doctor:

(or place Patient Identification Label here)

Doctor Name:	Date of Referral:
Provider Number:	Cardiologist:
Phone:	Fax:
Email:	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. falls, cognition, comments)		
Medications on Discharge:		

Health Professional Completing Referral:	Date: / /
Signature:	Contact Number:

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