NORTH VANCOUVER
Recreation
& Culture

851 West Queens Rd. North Vancouver, BC V7N 4E3
P. **604.983.6401** F. **604.983.6343** **www.nvrc.ca**

## Cardiac Rehabilitation Program

# Physician Referral Form

All participants must be referred to the program by their physician.
To get a referral, please bring this form to your doctor.

Name: ______________________ Age: ____________ Date of Birth: ______________

Address: ______________________ City: ____________ Postal Code: ______________

Phone: __________________________ Email: __________________________

Care Card: ____________ Family Physician: ______________ Cardiologist: ____________

## Risk Factors

| | Yes | No | Date | Outcome |
|---|---|---|---|---|
| Hypertension | ☐ | ☐ | ________ | ______________ |
| Dyslipidemia | ☐ | ☐ | ________ | ______________ |
| Obesity | ☐ | ☐ | ________ | ______________ |
| Diabetes | ☐ | ☐ | ________ | ______________ |
| Pre Diabetes | ☐ | ☐ | ________ | ______________ |
| Valve Surgery | ☐ | ☐ | ________ | ______________ |
| Dysrhythmias | ☐ | ☐ | ________ | ______________ |
| Stable Cardiac Disease | ☐ | ☐ | ________ | ______________ |
| Pace Maker/Defibrillator | ☐ | ☐ | ________ | ______________ |

**Please attach if available:**

- Recent exercise stress test (if not completed recently, one will be conducted)
- Most recent lipid profile • Other pertinent cardiac test results

*I consider my patient, named above to be a reasonable candidate for a medically supervised cardiac rehabilitation program.*

## Consent of Physician

Signature: ______________________ Phone: ______________________ Date: ____________

## Locations:

**Memorial Community Recreation Centre** 125 E 23rd St V7L 2E2 / 604.983.6402
**Parkgate Community Centre** 3625 Banff Court, V7H 2Z8 / 604.983.6350
**Ron Andrews Community Recreation Centre** 931 Lytton St V7H 2M5 / 604.983.6500
**John Braithwaite Community Centre** 145 W 1 St V7M 1B1 / 604.983.6471

**Medical Director**
**Dr. Kevin McLeod MD, FRCPC, ABIM**