# Referral Form for The Heart Fit Clinic

Fax: 519-977-2333 Tel: 519-977-2333 www.heartfit.ca

## Patient Information

Last Name: _____

First Name: _____

DOB: _____/_____/_____
YY MM DD

Home Address: _____

PHN Number: _____

Contact Number: _____

## Clinic Information

Clinic Name: _____

Referring Practitioner: _____

Fax Number: _____

Phone Number: _____

Date Referral Sent: _____/_____/_____
YY MM DD

## Reason For Referral

- ❑ Primary Prevention
  - ❑ Hypertension
  - ❑ Dyslipidemia
  - ❑ Diabetes / Pre-diabetes
  - ❑ Overweight
  - ❑ Inactivity
- ❑ Secondary Prevention

## Cardiac Services

- ❑ Integrative Cardiac Assessment
- ❑ Cardiac Rehabilitation
  - ❑ Clinical Exercise Program
  - ❑ External Counterpulsation Therapy
- ❑ Echocardiogram
- ❑ Carotid Ultrasound
- ❑ 1–2-week Holter/ECG
- ❑ Private Cardiology