



New England Division of General Practice & Hunter New England Area Health Service

Glen Innes Cardiac Rehabilitation

GP REFERRAL FORM

Patient Name: _____ Referral Date: / / DOB: / /

Patient Address: _____

Phone (H): _____ (W): _____ Dept Veterans Affairs Recipient? Yes / No

Aboriginal/Torres Strait Islander? Yes No

1. Reason for Referral/ Current Diagnosis: _____

2. Diagnosis:

1 Angina /IHD _____ Date: _____

2 Post Infarct _____ Date: _____

3 CAGS/Heart Surgery _____ Date: _____

4 Angioplasty/ Stent _____ Date: _____

5 Valve Surgery _____ Date: _____

6 Other, including High Risk only patient (explain) _____

2.1 Risk Factors: _____

2.2 Last Cholesterol _____ mmol/L HDL _____ mmol/L LDL _____ mmol/L
Triglycerides _____ mmol/L Date/...../.....

2.3 Additional Concerns: _____

2.4 Medication(s)(Or attach list): _____

2.5 Stress Test: Yes/No Results: _____

3. I would like my patient to attend Group Exercise and Education
 have home visits only OR
 both

Referral approved by: Dr _____ (Please print or type name)

Signed: Dr _____ GP's Phone No: _____

PHONE BOOKINGS ESSENTIAL _____

Please phone Rosemary Willis on 02 6739 0100 to ensure a place in the program.

Then please return this form to: Rosemary Willis, Glen Innes Community Health Centre, Fax: 02 6739 0105