



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

Glen Innes Cardiac Rehabilitation Program

Doctors referral form

Referral Date: / /

Patient Name: _____

DOB: / /

Address: _____

Phone: (H) _____ (W) _____ Dept. Veterans Affairs recipient? Yes No

Are you of Aboriginal or Torres Strait Islander origin? Yes No

1. Reason for Referral/Current Diagnosis: _____

2. Recommended Program (please circle): Group Program / Home-Based

3. Diagnosis:

- | | | |
|---|-------|-------------|
| 1. <input type="checkbox"/> Angina/IHD | _____ | Date: _____ |
| 2. <input type="checkbox"/> CABGS | _____ | Date: _____ |
| 3. <input type="checkbox"/> AMI/MI | _____ | Date: _____ |
| 4. <input type="checkbox"/> Angioplasty/ Stent(s) | _____ | Date: _____ |
| 5. <input type="checkbox"/> Valve Surgery | _____ | Date: _____ |
| 6. <input type="checkbox"/> Other, including High Risk Only Patient (Explain) | _____ | |

3.1 Risk Factors: _____

4. Last Cholesterol _____ mmol/L HDL _____ mmol/L LDL _____ mmol/L
Triglycerides _____ mmol/L HbA1c _____ Date: _____

5. Additional Concerns: _____

6. Medication(s): (or attach list) _____

7. Stress Test: Yes No Results: _____

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

Signed: Dr _____ Phone: _____

PHONE BOOKINGS ESSENTIAL

Please phone to ensure a place in the program. Phone Rosemary Willis on (02) 6739 0100. Then please return this form to:

Rosemary Willis
Glen Innes Community Health



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

Fax (02) 6739 0105