NQ0030

CARDIAC REHABILITATION REFERRAL

Facility: .....

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

Please return completed forms to: Email: alliedhealthadmin@mater.org.au Phone: 07 4727 4650 Fax: 07 4727 4669

Eligibility criteria for cardiac rehabilitation is as follows: STEMI, NSTEMI, CABG, valve surgery, elective PCI, heart failure, arrythmia, AICD/PPM, angina pectoralis, congenital heart disease, congenital heart surgery, TAVI or medically managed heart condition.

Cardiac Rehabilitation Referral Details

Reason for referral	
Relevant history *(please attach report as necessary, e.g. health or discharge summary, ECG, medication list)*	
Infection control needs	☐ Yes ☐ No If *YES*, please list: .....
Recommended start date	..... / ..... / ..... ☐ ASAP

Referrer Details

Referrer stamp

Name:

Medical centre:

Contact details:

Signature: Date: ..... / ..... / .....

Binding margin - do not write. Do not reproduce by photocopying.
All clinical form creation and amendments must be conducted through Health Records.

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04/23
Ver. 3.00
NQ0030