



# 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, arrhythmia, 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

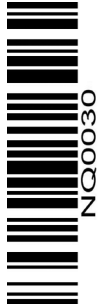
*Referrer stamp*

Name: .....

Medical centre: .....

Contact details: .....

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



NQ0030

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