UNIVERSITY OF OTTAWA HEART INSTITUTE
INSTITUT DE CARDIOLOGIE DE L'UNIVERSITÉ D'OTTAWA

PREVENTION & WELLNESS CENTRE
CENTRE DE LA PRÉVENTION ET DU MIEUX-ÊTRE

Prevention and Wellness Centre – CardioPrevent Referral Form
**PLEASE FAX TO 613-696-7194 • TEL:613-696-7071**

Our primary prevention programs aim to lower the risk of cardiovascular disease in participants with no known CVD and/or cerebrovascular disease.

**ALL FIELDS ARE MANDATORY**

## REFERRAL

Last name: _____ First name: _____ Stamp:
Date of Birth (YYYY/MM/DD): _____ Phone: _____
Address: _____ City: _____
Province: _____ Postal code: _____
Health card No. _____ Expiry date: _____
Sex: _____ Indigenous: ☐ Yes ☐ No

## REASON FOR REFERRAL

☐ Risk Factor Management Consultation ☐ Risk Factor Management Consultation **(Postpartum)**

## EXCLUSION CRITERIA

**If you answer yes to any of the following questions, the patient is not eligible for the program.**

Diagnosis of cardiovascular disease? (i.e. heart disease, heart attack, valve disorder, heart surgery, had a stent) ☐ Yes ☐ No
History of "mini stroke" (TIA) or a stroke, brain aneurysm, or cerebrovascular disease? ☐ Yes ☐ No
Abdominal aortic aneurysm? ☐ Yes ☐ No

## PREFERRED LANGUAGE OF SERVICE:

☐ English ☐French ☐Other: ☐ Interpreter required

## FIELDS MANDATORY FOR POSTPARTUM ONLY:

Expected due date or delivery date (YYYY/MM/DD): _____ ☐ Currently pregnant
Select conditions that apply: ☐ Pre-eclampsia/eclampsia ☐ HELLP syndrome ☐ Gestational diabetes ☐ Gestational hypertension

## CLINICAL INDICATIONS – All fields mandatory

Blood pressure _____ / _____ mmHg ☐ **Medication list - attached**
Hypertension? ☐ Yes ☐ No Diabetes? ☐ Yes ☐ No
High cholesterol (Dyslipidemia) ☐ Yes ☐ No Family history of early onset cardiovascular disease? ☐ Yes ☐ No
Overweight/obesity? ☐ Yes ☐ No Smoker? ☐ Smoker ☐ Quit in the past 6 months
☐ Non-Smoker, never smoked ☐ Quit more than 6 months ago

## RESULTS OF RECENT BLOOD VALUES (WITHIN THE PAST 6 MONTHS) – All fields mandatory

☐ **Labs - attached**

Total Cholesterol _____ mmol/L Triglycerides _____ mmol/L
LDL-C _____ mmol/L Fasting Glucose _____ mmol/L
HDL-C _____ mmol/L HbA1C _____ %
TC/HDL-C _____

## CHALLENGES THAT MAY IMPACT LEARNING OR SERVICES REQUESTED

☐ Cognitive impairment ☐ Developmental challenges ☐ No MD/NP ☐ Literacy
☐ Mobility issues ☐ Problematic drug/alcohol use ☐ Homeless/marginal housing ☐ Mental health challenges

## APPROPRIATE FOR GROUP SESSIONS?

☐ Yes ☐ No

## ADDITIONAL COMMENTS/SPECIAL INSTRUCTIONS:

## REFERRING PROVIDER (or stamp)

Name:
Address:
Phone:
Fax:
Signature: _____