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: ______