Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

Cardiac Sciences Program / Programme des sciences cardiaques

Cardiac Rehabilitation Referral

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address (home visits only)

These diagnoses are acceptable for admission to Cardiac Rehabilitation.
Please check the primary diagnosis and/or relevant interventions.

Indications for Cardiac Rehabilitation

☐ Coronary Artery Disease
- ☐ Acute coronary syndrome
- ☐ Stable ischemic heart disease
- ☐ Coronary artery bypass graft (CABG)
- ☐ Percutaneous coronary intervention

☐ Heart Failure
- ☐ Systolic dysfunction
- ☐ Symptomatic heart failure with preserved ejection fraction (HFPEF)
- ☐ Cardiac transplant or ventricular assist device
- ☐ Congenital cardiomyopathies

☐ Arrhythmia
- ☐ Ventricular tachycardia or ventricular fibrillation
- ☐ Chronic atrial fibrillation or atrial flutter
- ☐ Electrophysiology study (EP study) with ablation procedure
- ☐ Implantable cardiac defibrillator

☐ Complex Congenital Heart Disease
- ☐ Post surgical repair
- ☐ Post percutaneous intervention
- ☐ Chronic significant shunts
- ☐ Palliative procedure

☐ Valve Disease
- ☐ Surgical valve repair or replacement
- ☐ Percutaneous valve repair or replacement
- ☐ Palliative non-repairable severe valve disease

☐ Symptomatic Peripheral Artery Disease
- ☐ Claudication symptoms
- ☐ Surgical revascularization of peripheral artery disease
- ☐ Percutaneous procedure of the aorta or of peripheral artery disease

☐ Other

Requires approval by the Cardiac Rehabilitation Medical Director. Email: *cardiacrehabinfo@sbgh.mb.ca*
- ☐ Approval Received

NAME: _____ PHONE #: |_|_|_|-|_|_|_|-|_|_|_|_|

ADDRESS: _____ POSTAL CODE: |_|_|_|_|_|_|

PHIN: |_|_|_|_|_|_|_|_|_| HEALTH CARD #: _____

DATE OF BIRTH: |_|_|_|_|_|_|_|_| (D D M M M Y Y Y Y)

ALTERNATE CONTACT: _____ PHONE #: |_|_|_|-|_|_|_|-|_|_|_|_|

Date Of Event (if applicable): |_|_|_|_|_|_|_|_| (D D M M M Y Y Y Y)

☐ **Reh-Fit Centre** . . . . . **Fax: 204-928-7690** ☐ **Wellness Institute** . . . . **Fax: 204-694-2712**

Primary Care Provider Signature: _____ Date: |_|_|_|_|_|_|_|_| (D D M M M Y Y Y Y)

Primary Care Provider Printed Name and Designation: _____

OFFICE USE ONLY: _____ ☐ FAX SENT

_____ |_|_|_|_|_|_|_|_| (D D M M M Y Y Y Y) |_| INITIAL