

**REFERRAL - CARDIAC REHABILITATION**

All enquiries to (08) 7117 0600

Monday to Friday 9am – 5pm

SEND COMPLETED REFERRAL TO:

▪ E-mail [health.chsacardiarehab@sa.gov.au](mailto:health.chsacardiarehab@sa.gov.au)

▪ Fax- (08) 7117 0635

UR Number:			
Title:		Surname:	
Given Names:			
Alias:			
D.O.B		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Medicare No.			
DVA	<input type="checkbox"/> Yes <input type="checkbox"/> No	DVA No:	
<b>Complete details or affix client identification label</b>			

**Complete all relevant sections (Please print clearly)**

<b>Client/patient contact details</b>	Address 1:		City/Suburb:					
	Address 2:		Postcode:	State:				
	Phone:		Mobile:					
	Aboriginal or Torres Strait islander:		<input type="checkbox"/> YES <input type="checkbox"/> NO					
	Email:		<input type="checkbox"/> PUBLIC CARDIAC REHAB <input type="checkbox"/> PRIVATE CARDIAC REHAB					
	Nominated Cardiac Rehab Site:							
<b>Hospital Admission Details</b>	Admission Date:	Date of Discharge		Transferred to				
<b>Inpatient cardiac rehabilitation review</b>	Was this person reviewed by a cardiac rehabilitation nurse whilst an inpatient in hospital?		<input type="checkbox"/> NOT APPLICABLE <input type="checkbox"/> YES <input type="checkbox"/> NO	Phase 1 Completed <input type="checkbox"/> YES <input type="checkbox"/> NO				
<b>Referrer details</b>	Name:	Role Organisation		Date of Referral				
<b>Cardiologist details (if applicable)</b>	Name:		Organisation:					
	Address:							
	Phone:	Fax:	E-mail:					
<b>Client/patient's GP or other primary health care provider details</b>	Name:		Practice:					
	Address:							
	Phone:	Fax:	E-mail:					
<b>Has the patient been given the following written resources?</b>	<b>MY HEART MY LIFE</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN					
	<b>MY HEART MY FAMILY OUR CULTURE</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE					
<b>Principal diagnosis or reason for referral</b>								
<b>Current medications (Attach list if necessary)</b>								
<b>Relevant medical history summary (Attach list if necessary)</b>								
<b>Risk Profile:</b>	LDL		HDL		Triglycerides		Total Cholesterol	
	Test Date:	Height (cm)	Weight (kg)		Smoker / Ex-Smoker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood Pressure	