HEADWATERS Health Care Centre

Patient Identification Label

Cardiac Wellness Program Referral

Name:		Health Card Number:		VC:	
Address:	Street	City	Province	Postal Code	
Telephone:	Home	Business	Birth Date:	DD/MM/YYY	
Family Physician:					

Medical Information:

Angina Class	(Circle one):	0	I	II	III	IV
M.I.	☐ Yes	☐ No	Date:		Type:	
			Date:		Type:	
Angiogram	Date:					
Angioplasty	Date:					
Cardiac Surgery	Date:		Type:			
Medications:						

Risk Factors:	**Smoking**	☐ Yes	☐ No	**Hypertension**	☐ Yes	☐ No	**Hyperlipidemia**	☐ Yes	☐ No
	Diabetes	☐ Yes	☐ No	**Has attended Diabetes Management Program?**				☐ Yes	☐ No
	Family History:		☐ Yes	☐ No					
Additional Pertinent History									
Referring Physician	Signature			OFFICE STAMP					

Please Forward Completed Form To:
Headwaters Health Care Centre, Cardiac Wellness Program
100 Rolling Hills Drive,
Orangeville, Ontario L9W 4X9
Email – cardiacwellness@headwatershealth.ca
Fax – 519-943-7221

H.CARDWELL