



Cardiac Disease Prevention and Rehabilitation Unit

Referral Form

Please fill out this form on behalf of your patients to be referred to the Cardiac Disease Prevention and Rehabilitation Unit (CDP&R) Programme at the Heart and Stroke Foundation of Barbados Inc.

Please provide your patient's biographical details below.

Referral Date: _____ Hospital No.: _____

Name: _____ National ID No: _____

Address: _____

Tel. No: _____ Home _____ Work _____ Mobile _____

Email: _____

Indication for Cardiac Rehabilitation (please select ALL that apply)

Date of qualifying diagnosis: _____

Cardiovascular Diagnosis

- Recent Myocardial Infarction
- Post Coronary Artery Bypass Surgery
- Stable Angina
- Percutaneous Coronary Intervention
- Valve Repair/Replacement
- Systolic Heart Failure; EF <35% with optimal medical therapy
- Peripheral Arterial Disease
- Other _____

Additional Cardiac/ Vascular Diagnoses: (please select ALL that apply)

- Hypertension
- Hyperlipidemia
- Diabetes
- Heart Failure
- CVA/TIA Type: _____ Deficits: _____
- Risk factor reduction
- Other : _____

Significant Medical/Orthopedic Problems (Please Check): Yes No

Description: _____

Completed Investigations:

ECG showed: _____

Lipid profiles: Total Cholesterol: _____ HDL _____ Triglycerides _____ LDL _____

GXT results : Mets Achieved: _____ Max HR achieved: _____ Conclusion: _____

ECHO: _____

CT Brain: _____

MRI: _____

Coronary angiogram result: _____

Other: _____

Treatment:

Surgery / percutaneous procedure performed: _____ Date: _____

Physiotherapist assessment (*needed for stroke rehab admission*): _____

Other:

♥ Admission to the program is dependent upon receipt of the most recent ECG, blood lipid results, ECHO, CT brain, cardiac catheterization report and any other investigation results assessed that were checked above.

Referring Physician's Name (Please Print): _____

Tel. No. : _____ Address: _____

Physician Signature: _____ Consultant: _____