HEADWATERS Health Care Centre

Cardiac Wellness Program Referral

Name: _____ Health Card Number _____ VC_____

Address: _____
Street Town Province Postal Code

Telephone: _____ _____Birth Date: _____
Home Business

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 Stamp

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