

PLEASE FAX FORM TO 604-875-3136 WE WILL CONTACT PATIENT FOR APPOINTMENT

Patient Information

Last Name: _____ First Name: _____ Initial: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone (Home): _____ (work): _____ (cell) _____

PHN: _____ DOB (DD/MM/YYYY) _____

Support Person: _____ Family Doctor: _____ Medical ID# _____

Date of Appointment: _____ Today's Date: _____

Reason(s) for Referral:

Must have one of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> High Cholesterol / Dyslipidemia | <input type="checkbox"/> Physical Inactivity | <input type="checkbox"/> Hx of Gestational Diabetes
(six weeks postpartum) |
| <input type="checkbox"/> Obesity / Overweight | <input type="checkbox"/> Family History of Vascular Disease | <input type="checkbox"/> Hx of Gestational Hypertension
(six weeks postpartum) |
| <input type="checkbox"/> Pre-Diabetes/Diabetes | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Sleep Apnea | |
| <input type="checkbox"/> HTN | <input type="checkbox"/> Metabolic Syndrome | |

Medication

Include dose. Please include lipid medication history if relevant.

Laboratory Results

Include a copy of lipid profile and FBG results within last 6 months.
 (TC, HDL, LDL, CRP, TSH, GFR, HgBA1C, Urine ACR)

Cardiac Investigations

Include a copy of any relevant cardiac tests that have been done
 (ie- stress tests, ECG, echocardiogram, carotid dopplers)

I would like myself / my patient to be seen for the following:

- | | |
|---|--|
| <input type="checkbox"/> Cardiovascular risk assessment | <input type="checkbox"/> Pre-Diabetes / Diabetes |
| <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other: _____ |

All patients receive intensive risk factor assessment and counseling on family hx, lifestyle, nutrition, exercise, and smoking cessation from a Nurse Practitioner with follow-up as needed to achieve recommended targets.

Referring Healthcare Provider:

Office Address / Phone: