REFERRAL FORM

WHITE ROCK | 101 – 1959 152nd Street
Phone: 604.541.2846 | **Fax: 604.424.4183**

LIVE WELL
MEDICAL + EXERCISE CLINIC
Physician Prescribed Exercise Programs

1. PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female

Address: _____ Language: _____

Phone: _____ DOB *(mm/dd/yyyy)*: _____ Care Card: _____

2. SELECT A LIFESTYLE PROGRAM

Personalized exercise programs developed by a Clinical Exercise Physiologist, nutrition counselling, health education, 1:1 nursing consultations, psychology treatment assessment, and comprehensive lifestyle change. (Fee for service)

☐ **DIABETES** | Get To Target
Customized for Type II diabetics who are newly diagnosed, new insulin starts and/or not on target.
☐ **YES, refer patient to Dr. Ali Zentner**

☐ **OBESITY** | My Healthy Weight
Led by Obesity Expert, Dr. Ali Zentner, referrals are accepted for those with a BMI>30. The focus is healthy eating habits, activity, and emotional health.
☐ **YES, refer patient to Dr. Ali Zentner**

☐ **CARDIAC REHABILITATION** | Heart Strong
An innovative, comprehensive & highly effective approach to cardiac rehab with expert support & individualized care.
All patients supervised by a Cardiologist.
☐ **YES, refer patient to Dr. Jiao Yang**

☐ **PREVENTION** | Pro Active
Appropriate for on target diabetics and stable cardiac patients. Focus is on risk factor reduction: high blood pressure, high cholesterol, impaired fasting glucose, physical inactivity, overweight, stress reduction, depression treatment, family history, smoking cessation.
☐ **YES, refer patient to next available specialist**

☐ **OTHER** (Please specify):
_____

3. REFER TO A SPECIALIST

Process No-Charge Referral 3333

☐ **CARDIOLOGY**
☐ **PACEMAKER CLINIC**
☐ **CHEST PAIN CLINIC**
☐ **CHF CLINIC**
☐ **LIPID CLINIC**

Jiao Yang MD, FRCPC (MSP #63803)
Cardiologist

☐ **VASCULAR SURGERY**

Nadra Ginting MD, FRCSC (MSP #65296)
Vascular Surgeon

4. DIAGNOSTIC CARDIAC SERVICES

****Rapid access at:* ***bookit.livewellclinic.ca****

☐ **HOLTER MONITOR**
☐ **CARDIAC STRESS TEST**
☐ **AMBULATORY 24H BP**
($50 fee, subsidy available)
☐ **ECG**
☐ **ABI / PAD STUDY**

5. DETAILS OF REFERRAL *(Mandatory Field)*

For Sections 2) and 3), please provide medical history, current medications, and most recent bloodwork.

PRIMARY CARE PROVIDER CONTACT INFORMATION:

Name: _____

Phone: _____ Fax: _____

REFERRING PHYSICIAN CONTACT INFORMATION:

Name: _____

Phone: _____ Fax: _____

6. SIGNATURE OF REFERRING PHYSICIAN

X _____ **MSP**: _____ **DATE** *(mm/dd/yyyy)*: _____

Appropriate patients will be stress tested as per the AHA/ACC guideline on exercise testing (J Am Coll Cardiol. October 16, 2002,40(8):1531-1540)