

**PHYSICIAN REFERRAL: Sea to Sky Healthy Heart Program**  
**Fax to: 604-892-2327**

Name:		Date of Birth:	Age:
PHN#:		Address:	
Telephone: (    )		Email:	
Physician Name: MSP #:		Specialist:	
<b>Medical History / Risk Factors</b>			
<input type="checkbox"/> Cholesterol / Dyslipidemia <input type="checkbox"/> Obesity / Overweight <input type="checkbox"/> Diabetes <input type="checkbox"/> Impaired Fasting Glucose (IFG) or Impaired Glucose Tolerance (IGT)	<input type="checkbox"/> Smoker <input type="checkbox"/> Hypertension <input type="checkbox"/> Physical inactivity <input type="checkbox"/> Psychosocial factors <input type="checkbox"/> Family hx of vascular disease (1 <sup>st</sup> degree relative $\leq$ 65 yrs)	<input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Cerebral vascular disease <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Other: _____	
<b>Other Medical / Surgical History:</b>			
<b>Current Medications:</b> Include dose. Please include lipid medication if relevant.			
<b>Laboratory Results:</b> Include copy of lipid profile results within last 6 months (total chol, TG, HDL, LDL, ratio, fasting plasma glucose)			
<b>Cardiac Test Results:</b> Include copy of stress test(s) (within 1 year), electrocardiogram, echocardiography, angiogram			
<b>Required</b>			
1. Target BP: _____ HR: _____			
2. Fluid Restriction (if applicable): _____ /day			
3. This patient is safe to participate in the physical exercise component of the program: <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Please indicate if you would like your patient to be seen by the Healthy Heart physician lead and Internal Medicine specialist Dr. Yashar Tashakkor in Squamish prior to commencing the program <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician Name:		Signature:	Office Contact:

**Patient will be triaged and contacted by the Healthy Heart Program to complete registration.**