South West Health

Cardiovascular Clinic
Self-Referral Form

Please print clearly.

Name: _____ **Daytime Phone number:**_____ **Address:** _____ _____ **Health Card Number:** _____ **Date of Birth:** _____ **Family Physician:** _____	Office Use Only

Allergies: _____

Medications (List all over the counter and prescription medications):

_____
_____
_____
_____

To be seen in the Cardiovascular Clinic you must have had at least one of the following:

- ☐ Stroke, Date(s): _____
- ☐ Mini Stroke or TIA, Date(s): _____
- ☐ Heart Attack, Date(s): _____
- ☐ Angina or Chest Pain, Date(s): _____

Please indicate if you have any of the following:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Irregular Heart Rhythm
- ☐ Smoking
- ☐ Unhealthy eating
- ☐ Overweight
- ☐ Inactivity

Please list your reasons for wanting a referral to the Cardiovascular Clinic:

_____
_____
_____
_____

Note: If you have a Family Physician, he/she will be contacted.

Signature: _____ ***Date:*** _____

Please send referral to the SWH Cardiovascular Clinic at the Yarmouth Regional Hospital, 4th Floor – Building C – Wellness Centre, 60 Vancouver Street, Yarmouth, NS B5A 2P5
Fax: 902-742-5170 Phone: 902-742-3542 ext. 460

NU-405

For Office Use Only: Code #: _____ Initial appt: _____ / _____
Date received: _____ (Date) (Time)