HEALTH COLLABORATIVE
Dr. M. Coons

Cardiac Referral Form

PATIENT FIRST NAME

PATIENT LAST NAME

DATE OF BIRTH (mm/dd/yyyy)

STREET ADDRESS

CITY

TELEPHONE NUMBER

EMAIL ADDRESS (OPTIONAL)

PRESENTING PROBLEM

NATURE OF CARDIAC ISSUES (Check all that apply)

- ☐ Coronary Artery Disease
- ☐ Angioplasty
- ☐ MI
- ☐ CABG
- ☐ Heart Valve Surgery
- ☐ Device Implant (e.g., ICD)
- ☐ Heart Failure
- ☐ Other

CURRENT TREATMENTS (Check all that apply)

- ☐ Medications
- ☐ Psychological Treatents
- ☐ Exercise / Physiotherapy
- ☐ Occupational Therapy
- ☐ Device Implant (e.g., ICD)
- ☐ Surgical
- ☐ Other
- ☐

OTHER COMPLAINTS (Check all that apply)

- ☐ Insomnia
- ☐ Unrefreshing Sleep
- ☐ CPAP non-adherence
- ☐ Self-Management Non-Adherence
- ☐ Rehab from Illness / Injury
- ☐ Adjustment Problems
- ☐ Depression
- ☐ Anxiety
- ☐ Trauma / PTSD

FUNDING:

- ☐ Private Insurance
- ☐ Veterans Affairs
- ☐ Self Pay

OTHER COMPLAINTS (continued)

- ☐ Stress Management
- ☐ Relationship Problems
- ☐ Sexual Dysfunction
- ☐ Weight Management / Bariatrics
- ☐ Other

REFERRING CLINICIAN

REFERRING CLINICIAN TELEPHONE #

REFERRING CLINICIAN FAX #

Completed referrals can be faxed confidentially to Dr. Michael Coons at (905) 333-1936
Please include copies of available consultation notes.