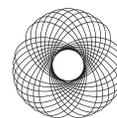


REFERRAL FORM

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): _____