Singapore Heart Foundation
Your Heart *We* Care

Referral Form

Client	Referred by
Client's Sticky Label (Name, DOB, Gender) **OR** fill in below: Mrs/Ms/Mr_____ NRIC: S / T XXXX ☐☐☐-☐ Gender: M / F _____ DOB: _____ **Tel / HP:** _____ **Email:** _____	To the best of my knowledge, this client is **not** diagnosed with any of the conditions stated in the below exclusion criteria. He/she is **suitable** to join a community exercise programme. Name of Dr / Cardiac Rehab Physiotherapist / Nurse _____ Clinic / Hospital _____ Contact No / Email _____ Signature _____ Date _____

Inclusion Criteria	Exclusion Criteria
☐ Post-cardiac procedures; e.g. CABG, PCI, valve replacement / repair ☐ Asymptomatic ischaemic heart disease ☐ Stable angina ☐ Stable chronic heart failure ☐ Hypertension ☐ Diabetes mellitus ☐ Impaired glucose tolerance ☐ Dyslipidaemia ☐ Insertion of Pacemaker/ ICD/ CRT-D/P ***Please state the upper rate limit/VT1 Threshold for the device: _____bpm*** *(If known)*	☐ Does the patient have **any uncontrolled/unresolved/unstable/acute medical condition**? (e.g., uncontrolled atrial fibrillation, untreated aortic dissection, acute kidney injury, heart failure NYHA III / IV) ☐ Does the patient have **any cognitive dysfunction that requires constant attention**? (e.g., impulse control disorders, severe dementia, moderate-to-severe cognitive impairment) ☐ Does the patient **require physical assistance** regarding his/her mobility? (e.g., bilateral loss of sensation in the lower limbs, severe osteoarthritis, severe deconditioning) ☐ Left ventricular ejection fraction < 40% and/or is categorised as a **NYHA Class III / IV**? **(Patients with Heart Failure are accepted on case-by-case basis)*

Clinical / Medical Summary
Ejection Fraction (EF): **Date of Discharge:** **Details of diagnosis and procedures (i.e., CABG, Cath/PCI):** *Please include the relevant date and any intra/post OP events*

Please turn over

Clinical / Medical Summary (Cont'd)

Any Significant Arrhythmias, Baseline ECG rhythm?

Relevant Past Medical History (e.g. Investigations, History of TIA, Parkinson's, etc.)
(This information will allow us to better understand the client's profile to make more informed decisions about their exercise prescription.)

Any exercise precaution for us to take note of?

Kindly attach report(s) of all medical investigations done (e.g. Treadmill stress test, 2-D Echo, Lipid profile etc), if any. Thank you!

Acceptance to the programme is subjected to the discretion of the SHF physiotherapists.

Phase 2 Cardiac Rehabilitation

Has the client undergone Phase 2 Cardiac Rehabilitation?

☐ **Yes** ☐ **No** ☐ **Not Applicable**

If Yes:

How many cardiac rehab sessions did the client undergo? _____

Date & 6-minute walk test distance (if applicable): _____

Date & Heart Rate Walking Speed Index (if applicable): _____

Final Target Heart Rate prescribed: _____

Please tick the preferred Health Wellness Centre (HWC) accordingly below.

☐ **Heart Wellness Centre @ Bishan**
9 Bishan Place #07-01
Junction 8 (Office Tower)
Singapore 579837
Tel: 6354 9348 / 63
Fax: 6258 5240
Email: hwc1@heart.org.sg

☐ **Heart Wellness Centre @ Fortune Centre**
190 Middle Road #04-34
Fortune Centre (Retail Section)
Singapore 188979
Tel: 6336 9337
Email: hwc2@heart.org.sg

☐ **Heart Wellness Centre @ Gombak**
810 Bukit Batok West Ave 5
Bukit Gombak Sports Hall
#02-02, Singapore 659088
Tel: 6337 9318 / 12
Fax: 6337 9336
Email: hwc3@heart.org.sg

This referral is to be handed to a HWC staff before booking an initial assessment. Clinicians may email this referral to the preferred HWC via the respective email address above. Thank you.