

# Cardiac Care

## The Purpose

The sum of interventions required to ensure the best possible physical, psychological and social conditions so that individuals with chronic or post acute conditions may enhance the quality of their lives.

## The Program

A graduated process involving initial entry into an exercise environment which is closely monitored and primarily geared to educate, activate and promote individuals to pursue optimum wellness and commit to a complete lifestyle change. It is important to note that this transition takes TIME, SELF RESPONSIBILITY, and COMMITMENT.

## Cardiac Care Class

- Classes held 3 times per week at the Chilliwack Family YMCA Hocking Centre: Mondays, Wednesdays, and Fridays
- YMCA trained staff person as an exercise advisor
- Paramedic or trained nurse present
- Important to note that each participant exercises at an individual recommended pace according to their personal exercise prescription
- Education sessions given
- Recommended that clients participate in a minimum of three months in the Cardiac Rehabilitation program before graduating to a self-monitoring program in the facility

Updated: July 2010

## Pre-requisites

1. Doctor's completion of attached referral form. Please note: There may be a charge from your medical practitioner for completing the attached form.
2. Consultation\* to Cardiac Care: Individual consultation, assessment and exercise program design with instruction.

*\*Fee applies to consultation*

## Program Days & Times:

Mon/Wed/Fri  
7:30-9:00am or 8:30-10:00am

**Fee:** Cardiac Care membership  
3 month OR 1 year

*\*Speak with a Member Services Representative for current Membership rates & fees\**

**Please Note:** Prior to attending your first class, please RETURN your COMPLETED referral form to the YMCA.

Upon receipt of your completed form, you will be contacted by a **Cardiac Care Exercise Instructor** to set up an appointment for an initial assessment.

*Sponsorship: The Chilliwack Family YMCA offers special thanks to the Chilliwack Kiwanis Club for their donation of a defibrillator; Chilliwack Bingo, the Government of British Columbia, and Fraser Health for Funding.*



## Mission Statement:

The YMCA is a charitable association dedicated to the development of people in spirit, mind and body as well as the improvement of local, national and international communities.



# Cardiac Care

## Exercise Program



## Chilliwack Family YMCA

A division of the YMCA of Greater Vancouver

### Hocking Centre

45844 Hocking Ave., Chilliwack, BC, V2P 1B4  
Ph# 604-792-3371 Fax#: 604-792-7298

E-mail: [chilliwack@vanymca.org](mailto:chilliwack@vanymca.org)

Website: [www.vanymca.org](http://www.vanymca.org)

# CARDIAC REHABILITATION EXERCISE PROGRAM REFERRAL FORM

## APPLICANT

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Postal Code \_\_\_\_\_  
Phone (Res.) \_\_\_\_\_ (Bus.) \_\_\_\_\_

## PHYSICIAN

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Postal Code \_\_\_\_\_

## APPLICANT HISTORY

### 1. MYOCARDIAL INFARCTION

If "YES" please complete the following:

- A) Number of attacks 1 2 3 more  
B) Most recent attack Date \_\_\_\_\_

YES [ ] NO [ ]

C) Complications

- 1) Arrhythmias YES [ ] NO [ ]  
2) Syncope YES [ ] NO [ ]

### 2. ANGINA PECTORIS

### 3. ANGIOGRAM

If "YES" please state results: \_\_\_\_\_

YES [ ]

YES [ ]

### 4. OTHER HISTORY

- A) Congestive Heart Failure YES [ ] NO [ ]  
B) Hypertension YES [ ] NO [ ]  
C) Arrhythmias YES [ ] NO [ ]  
D) Intermittent Claudication YES [ ] NO [ ]  
E) Aneurysm YES [ ] NO [ ]  
F) Cerebrovascular Episodes YES [ ] NO [ ]  
G) Broncho-Pulmonary Disease YES [ ] NO [ ]  
H) Systemic Conditions (Diabetes, Anemias, etc.) YES [ ] NO [ ]  
J) Other \_\_\_\_\_

If "YES" to any of the above, please comment: \_\_\_\_\_

### 5. Would your patient benefit from a Healthy Heart Nutrition Class offered at Chilliwack General Hospital?

If yes, please include more recent cholesterol values: Total Chol \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_  
Ratio \_\_\_\_\_ TE \_\_\_\_\_

### 6. MEDICATIONS

Please list current medications: \_\_\_\_\_

### 7. STRESS TEST RESULTS

Date Completed: \_\_\_\_\_ Pertinent Info: \_\_\_\_\_  
Exercise Intensity Guidelines (suggested exercise heart rate): \_\_\_\_\_

### 8. CONSENT OF PHYSICIAN

I consider my patient, mentioned above, to be a reasonable candidate for a special, medically supervised,  
Physical Fitness Program:

Signed \_\_\_\_\_ Date: \_\_\_\_\_

### 9. CONSENT OF PATIENT

I \_\_\_\_\_ hereby give my permission for the above medical information to be  
transferred to the Chilliwack Family YMCA Cardiac Rehabilitation Program/Chilliwack General Hospital Healthy Heart Nutrition Class.  
Signed \_\_\_\_\_ Date: \_\_\_\_\_