

REQUEST FORM FOR REPRODUCTION

**Champlain Primary Care Cardiovascular Disease Prevention and Management Guideline, 2008 ©
Champlain Cardiovascular Disease Prevention Network**

I. CONTACT PERSON INFORMATION

Name: _____

Telephone: _____

Email: _____

II. ORGANIZATION INFORMATION

Organization Name: _____

Street Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

What type of organization are you (check one):

- Family Health Team
- Family Health Group
- Community Health Centre
- Hospital
- Other (specify): _____

Is your organization currently part of the Improved Delivery of Cardiovascular Care (IDOCC) initiative? (check one):

- Yes
- No

If yes, please identify the IDOCC facilitator's name: _____

III. DESCRIPTION OF REQUESTED USE AND/ OR MODIFICATION

Please describe how the Champlain Guideline will be used, including target audience.

Will the Champlain Guideline be modified in anyway? (check one):

- Yes
- No

If yes, please specify in detail the modifications requested and provide a rationale for the revision:

Please forward this information to:

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