



Regional Cardiovascular Rehabilitation Service Referral

Patient Information

Last name: _____ First name: _____
 Street address: _____ Gender: Male Female
 City: _____ Postal code: _____ Phone no.: _____
 Date of birth (DD/MM/YY): _____ Health card no.: _____

Referral Indication (Require established vascular disease)

| | Year | | Year | | Year |
|--|-------|--|-------|---|-------|
| <input type="checkbox"/> Cardiac admission to hospital within 1 year | _____ | <input type="checkbox"/> Angina | _____ | <input type="checkbox"/> Peripheral vascular disease | _____ |
| <input type="checkbox"/> Heart failure | _____ | <input type="checkbox"/> Acute Coronary Syndrome | _____ | <input type="checkbox"/> Non-debilitating stroke or TIA | _____ |
| <input type="checkbox"/> Dilated cardiomyopathy | _____ | <input type="checkbox"/> Myocardial infarction | _____ | <input type="checkbox"/> Valve repair or replacement | _____ |
| <input type="checkbox"/> Heart transplantation | _____ | <input type="checkbox"/> Angioplasty | _____ | <input type="checkbox"/> Renovascular disease | _____ |
| <input type="checkbox"/> Pacemaker/ICD | _____ | <input type="checkbox"/> Bypass surgery | _____ | <input type="checkbox"/> Diabetes, Age > 55, +2 additional risk factors | _____ |

History of Congestive Heart Failure

NYHA I II III IV

Ejection fraction _____% ECHO MUGA LV Angio MRI Date _____

Risk Factors

- Family history Hypertension Obesity (Waist: Male > 102 cm; Female > 88 cm)
 History of smoking Hyperlipidemia Microalbuminuria
 Diabetes

Patient Consent

I give _____ permission to provide the regional cardiovascular rehabilitation program with medical records or information pertaining to my cardiac rehabilitation care.

Patient signature: _____ Date: _____

Referral to cardiovascular rehabilitation includes referral for an exercise test for exercise prescription.

Physician / NP signature: _____ Date: _____ Phone no.: _____

Physician / NP printed: _____ Registration Number: _____

Please fax completed referral test results and clinical notes to 416-281-7280.
 For any other enquiries, please phone 416-281-7022 or (Toll Free) 1-855-448-5471.