North Simcoe Cardiovascular Rehabilitation Program

Referral Form

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 (Requires established vascular disease)

	Year		Year		Year
☐ Cardiac admission to hospital within 1 year	____	☐ Angina	____	☐ Peripheral vascular disease	____
☐ Heart failure	____	☐ Acute Coronary Syndrome	____	☐ Non-debilitating stroke or TIA	____
☐ Dilated cardiomyopathy	____	☐ Myocardial infarction	____	☐ Valve repair or replacement	____
☐ Heart transplantation	____	☐ Angioplasty	____		
☐ Pacemaker/ICD	____	☐ Coronary Bypass			

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 ☐ Microalbinuria

☐ Diabetes

Patient Consent

☐ Patient has provided their permission to provide the regional cardiovascular rehabilitation program with medical records or information pertaining to their cardiac rehabilitation care.

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
705-797-3127 For any other enquiries, please phone 705-797-3157