central east regional cardiac care program
CARDIOVASCULAR REHABILITATION SERVICE

Ontario
Central East Local Health Integration Network

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
☐ 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	____	☐ Renovascular disease	____
☐ Pacemaker/ICD	____	☐ Bypass surgery	____	☐ **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 ☐ Microalbinuria

☐ 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.

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