

REFERRAL FORM

PATIENT INFORMATION

NAME _____ SEX _____
(Please Print) Last Name First Name Middle Initial

DATE OF BIRTH _____ HEALTH CARD _____
Month/Day/Year

STREET ADDRESS _____ APT # _____

CITY _____ PROV _____ POSTAL CODE _____

TEL (____) _____ (____) _____ EMAIL _____
Home Mobile

Limited English Proficiency: ☐ Yes ☐ No Language: _____

CONTACT PERSON _____ TEL _____

This patient is being referred for a comprehensive cardiovascular rehabilitation program including medical consultation, cardiopulmonary stress test, exercise intervention, and access to dietitian, social work, and psychology services.

I would like to request optimization of medications for cardiovascular prevention. ☐ Yes ☐ No

REFERRAL DIAGNOSIS (check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> MI | <input type="checkbox"/> CABG | <input type="checkbox"/> PCI | <input type="checkbox"/> Valve Surgery/TAVI |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Pacemaker/ICD | <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> LVAD |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Vascular Surgery | <input type="checkbox"/> PVD | |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Diabetes/Prediabetes | <input type="checkbox"/> SCAD | <input type="checkbox"/> Cardiovascular Risk Factors |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Ablation/Cardioversion | |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Pericarditis | <input type="checkbox"/> Myocarditis | <input type="checkbox"/> Other: _____ |

REFERRING PHYSICIAN INFORMATION

NAME _____
(Please Print) Last Name First Name

ADDRESS _____ TEL _____ FAX _____

(Physician Signature) ☐ Family Medicine ☐ Cardiology/Internal Medicine ☐ Cardiovascular Surgery
☐ Nurse Practitioner ☐ Endocrinologist ☐ Other: _____

Family Doctor: _____
(if different from above)