

# 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
<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"/> Pacemaker/ICD	_____	<input type="checkbox"/> 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
- Microalbuminuria
- 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

