

**Referral to Cardiac Rehabilitation & Primary Prevention**  
 Women's Cardiovascular Health Initiative  
 76 Grenville Street Toronto Ontario M5S 1B2  
 Phone: (416) 323-6400 Ext. 4883  
 Email: [womenshearts@wchospital.ca](mailto:womenshearts@wchospital.ca) Fax: 416-323-6147



Name:	DOB: day/month/year
Address:	Telephone: (H) (w) Email:
Health Card Number:	
Referring MD's Name: Telephone:	Physician #: Fax:
<b><u>REFERRAL REQUIREMENTS:</u></b>	
<ul style="list-style-type: none"> <li>▪ <b>Please attach a recent exercise stress test (to expedite referral process)</b></li> <li>▪ <b>Please attach any recent cardiac test results, fasting lab results, and a copy of any cardiology, endocrinology and/or respirology consult notes</b></li> </ul>	

<b>Cardiac conditions and moderate-high risk profile:</b>
<input type="checkbox"/> CAD <input type="checkbox"/> CABG/PCI: date _____ <input type="checkbox"/> Other known cardiac condition: _____ date of diagnosis: _____ <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes: date of diagnosis: _____ <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Smoking  <b>Please describe relevant patient history:</b> (i.e. family history, stress/depression, obesity, etc.)

MD Signature: _____ Date: _____
<b>We will contact the patient to book an appointment</b>

For office use only:
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