Referral to Cardiac Rehabilitation & Primary Prevention

Women's Cardiovascular Health Initiative
76 Grenville Street Toronto Ontario M5S 1B2
Phone: (416) 323-6400 Ext. 4883
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WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Name:	DOB: day/month/year
Address:	Telephone: (H) (w) Email:
Health Card Number:	
Referring MD's Name:	Physician #:
Telephone:	Fax:

REFERRAL REQUIREMENTS:

- **Please attach a recent exercise stress test (to expedite referral process)**
- **Please attach any recent cardiac test results, fasting lab results, and a copy of any cardiology, endocrinology and/or respirology consult notes**

Cardiac conditions and moderate-high risk profile:

- ❑ CAD
- ❑ CABG/PCI: date _____
- ❑ Other known cardiac condition/surgery:_____date of diagnosis:_____
- ❑ Hypertension
- ❑ Diabetes: date of diagnosis:_____
- ❑ Hyperlipidemia
- ❑ Smoking

Please describe relevant patient history: (i.e. family history, stress/depression, obesity, etc.)

MD Signature: _____ Date: _____

We will contact the patient to book an appointment

For office use only: