

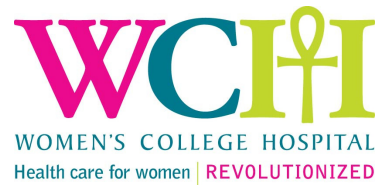
## Referral to Cardiac Rehabilitation & Primary Prevention

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:	Physician #:
Telephone:	Fax:
<b><u>REFERRAL REQUIREMENTS:</u></b> <ul style="list-style-type: none"><li>▪ Please attach a recent exercise stress test (to expedite referral process)</li><li>▪ Please attach any recent cardiac test results, fasting lab results, and a copy of any cardiology, endocrinology and/or respirology consult notes</li></ul>	
<b>Cardiac conditions and moderate-high risk profile:</b> <ul style="list-style-type: none"><li><input type="checkbox"/> CAD</li><li><input type="checkbox"/> CABG/PCI: date _____</li><li><input type="checkbox"/> Other known cardiac condition/surgery: _____ date of diagnosis: _____</li><li><input type="checkbox"/> Hypertension</li><li><input type="checkbox"/> Diabetes: date of diagnosis: _____</li><li><input type="checkbox"/> Hyperlipidemia</li><li><input type="checkbox"/> Smoking</li></ul> <p><b>Please describe relevant patient history:</b> (i.e. family history, stress/depression, obesity, etc.)</p>	
MD Signature: _____ Date: _____	
<b>We will contact the patient to book an appointment</b>	
For office use only:	