Referral to Cardiac Rehabilitation

Women's Cardiovascular Health Initiative
76 Grenville Street Toronto Ontario M5S 1B2
Phone: (416) 323-6400 Ext. 4883
Email: womenshearts@wchospital.ca Fax: 416-323-6147

WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

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

CVD diagnosis, event or procedure with date:	
❑ Angina _____	❑ Chronic atrial fibrillation _____
❑ ACS, angioplasty_____	❑ PVD _____
❑ CABG, valve surgery_____	❑ Non-debilitating stroke or TIA _____
❑ Pacemaker or ICD _____	❑ Reno-vascular disease _____
❑ Heart Failure _____	❑ Diabetes _____
❑ Cardiomyopathy _____	❑ Other _____

Please describe relevant patient history:

Please attach recent stress test, lab work and consult notes to expedite referral.

MD/NP Signature: _____ Date: _____

This referral includes access to entire Cardiac Rehab team, functional capacity test (stress test or 6-minute walk test) and lab work as appropriate.

For office use only:

☐ WCH myHealthRecord ☐ Video visit appropriate ☐ Decline video reason:_____

Please Fax or Email this referral form with pertinent documentation.
We will contact the patient to book an appointment.