WCHH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
M5S 1B2
Tel: 416-323-6400 x 4883 **Fax: 416-323-6304**

WOMEN'S CARDIAC REHABILITATION REFERRAL FORM

REFERRAL DATE: ____/____/_____
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:_____ HCN:_____

Name:_____

Sex:_____ Date of Birth:_____/_____/_____
DD / MM / YYYY

Address:_____

Telephone:_____ Alternate #:_____

ADDITIONAL PATIENT INFORMATION

Preferred name: Gender (*if not same as above*):

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ _____

Other insurance coverage (IFH, UHIP, etc.): ☐ Self-pay

Language spoken: Interpreter required: ☐ Yes ☐ No

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: _____

Signature: _____

☐ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: _____ Phone:_____ Fax:_____

REASON FOR REFERRAL

☐ Comprehensive Cardiac Rehabilitation (medical assessment, functional capacity test, lab work, exercise therapy, and access to Nurse Practitioner, Physiotherapist, Kinesiologist, Dietitian, Social Worker and Pharmacist)

☐ Virtual Group Education only (no medical consultations or access to team)

Please indicate date of cardiovascular disease diagnosis, event or procedure:

☐ Angina (i.e. microvascular disease): _____
☐ Acute Coronary Syndrome / Angioplasty: _____
☐ CABG, valve surgery: _____
☐ Pacemaker or implantable cardioverter defibrillator: _____
☐ Heart failure: _____
☐ Gestational complications (pre-eclampsia, gestational diabetes, postpartum heart conditions): _____
☐ Cardiomyopathy: _____
☐ Controlled atrial fibrillation: _____
☐ Peripheral vascular disease: _____
☐ Non-debilitating stroke or TIA: _____
☐ Diabetes: _____
☐ Hypertension: _____

Please attach all relevant results/reports including bloodwork, consultation reports, ECG and treadmill stress test.

ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):