



WOMEN'S COLLEGE HOSPITAL 76 Grenville Street  
 Toronto, Ontario  
 Healthcare | REVOLUTIONIZED M5S 1B2

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# 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: _____	Billing #: _____  Signature: _____
Address: _____	
Telephone: _____	
Fax: _____	

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): \_\_\_\_\_

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