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 (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 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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