Last Name, First Name	Date of Birth (DD/MM/YY)
Address	
Health Card Number	Home Phone

Cardiac Rehab Program
Tel: 226-806-5911
Fax: 226-806-5912

*Please include relevant clinical notes and investigations (e.g. coronary angiogram, stress test, echocardiograms, CV operative notes, hospital admission/discharge summaries and/or office consult notes. **NOTE: Referrals received without appropriate and sufficient accompanying clinical documents will not be processed.**

Cardiac Rehabilitation Referral Form

Indications (select all that apply):

❒ Coronary artery disease (e.g. prior MI/PCI/CABG, stable angina)

❒ Heart Failure/Cardiomyopathy

❒ Valvular Disease/Aortic Disease

❒ Peripheral Arterial Disease

❒ Arrhythmia (e.g. highly symptomatic Afib/flutter, prior VT/VF)

Referring Physician ______________________________ **Date** ______________________
Print Name

______________________________ **Fax** ______________________
Signature

FOR OFFICE USE ONLY

Date of Stress Test ______________________

Rescheduled ______________________

Revised March 2020