



Referral Form

First Name			Address		
Last Name					
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	City		
Date of Birth	(Mm/dd/yyyy)		Province		
Patient ID			Postal Code		
H.I.N.			Phone		
Version Code			E-Mail		
Family Doctor		Cardiologist / Internist		Surgeon	

Referring Clinician	<input type="checkbox"/> Family physician	<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Cardiac Surgeon	<input type="checkbox"/> Internist	
	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Other (specify) → _____		<input type="checkbox"/> Unknown	
	Point of Referral	<input type="checkbox"/> Emergency	<input type="checkbox"/> Cardiac Diagnostics/Intervention	<input type="checkbox"/> Inpatient Unit	<input type="checkbox"/> Physicians office
	<input type="checkbox"/> Outpatient Clinic	<input type="checkbox"/> Other (specify) → _____		<input type="checkbox"/> Unknown	
Referral Event	<input type="checkbox"/> MI	<input type="checkbox"/> PTCA	<input type="checkbox"/> CABG	<input type="checkbox"/> Aortic Valve	<input type="checkbox"/> Mitral Valve
	<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Transplant	<input type="checkbox"/> CHF	<input type="checkbox"/> Stable CAD	<input type="checkbox"/> Unstable Angina
	<input type="checkbox"/> Other (specify) → _____				

Referral Event Date _____ **Hospitalization Required** Yes No Unknown
 (Mm/dd/yyyy)

Please Choose a Care Path:

- Usual Program Care:** with risk stratification including pharmacologic and non-pharmacologic (nutrition, psychology, and exercise) treatment by the Cardiac Rehabilitation Team or referral to other medical specialties and services as needed.
- Limited Program Care:** with risk stratification including non-pharmacologic (nutrition, psychology, and exercise) by the Cardiac Rehabilitation Team with suggestions only for pharmacologic treatment to the primary or referring physician.

Please indicate cardiac rehab site and fax all pertinent discharge summaries, blood work, cardiac investigations (ECG, stress test, echo, MIBI, angio etc) along with the completed referral form.

WRH: Windsor Site (519) 257-5277

WRH: Leamington Site (519) 322-4616

Date _____ Referring Physician (Print Clearly) _____ Referring Physician Signature _____