Soldiers' MEMORIAL HOSPITAL Orillia

Apply Patient Label Here with min. of Name, DOB, Health Card #

Cardiac Rehabilitation Referral Form

*Note: Incomplete or illegible forms will be sent back requesting amendment

Patient Information:

Patient Name		
Patient DOB		
Primary Phone #		Alt. Phone #:
Health Card # (+ Version Code)		
OSMH MRN (if applicable)		

Referring Information:

Referring Physician (Family M.D/ Internist/Specialist/Nurse Practitioner)	Physician Name (print): ____ Physician Signature: ____
Office Telephone #	
Office Fax #	

Cardiovascular History (please check and comment as necessary):

MI; Date(s): ____

☐ NSTEMI / STEMI (*circle*) Location: ☐ Anterior ☐Inferior ☐ Posterior ☐Lateral

Other; Date(s): ______________________________________

☐ Unstable Angina ☐ Current Angina ☐ CHF ☐ PVD ☐ Stroke

☐ Dysrhythmias (specify): ____

☐ CABG ☐ PTCA ☐ Hypertension (BP = __________/__________)

Results (of CABG or PTCA): ____

Testing; Date(s): ____________________________________

☐ Echocardiography Ejection Fraction:___________________

☐ MUGA Ejection Fraction:___________________

☐ Stress Test Cardiolite / Persantine (*circle*) Results: ____

Lipid Profile; Date(s)_________________________________

Total Cholesterol:______ HDL-C: _____ LDL-C: ____ Triglycerides:_____

Additional Significant Medical Conditions:

☐ Diabetes ☐ Obesity ☐ Deconditioned ☐ Arthritis (specify) ☐ Musculoskeletal (specify) ☐ Pulmonary Disease (specify)

Other/Please Specify: ____

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Medications (Type & Dosage)

☐ Nitrates ☐Beta-Blocker ☐ ASA ☐ACE Inhibitor ☐ Diuretic ☐ Calcium Channel-Blocker
☐ Other (list below)

1. ______________________ 7. ______________________
2. ______________________ 8. ______________________
3. ______________________ 9. ______________________
4. ______________________ 10. ______________________
5. ______________________ 11. ______________________
6. ______________________ 12. ______________________

Comments/Special Concerns:

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Mail or Fax to: Coordinator, Cardiopulmonary Rehabilitation Program
Cardiopulmonary Rehabilitation
Orillia Solders' Memorial Hospital
170 Colborne Street West
Orillia, ON L3V 2Z3

FAX: 705 325 3985

Program Contacts:

Stefan Pingel, R. Kin, Coordinator
Phone (705) 327 9116

Dr. John MacFadyen, Medical Director
Phone (705) 325 1120

FOR OFFICE USE ONLY

Date Received *Date Patient Contacted*