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 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

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:

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
sfpingel@osmh.on.ca

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

FOR OFFICE USE ONLY

Date Received _____

Date Patient Contacted _____