ADDRESSOGRAPH

Cardiovascular Rehabilitation Program – Referral Form
FAX: 705-325-3985

Patient Information

Last Name: ________________________ First Name: ________________________

Mailing Address: ____

City: ________________, Ontario Postal Code:____________________

Date of Birth (DD-MMM-YY): ______-___________-______ Health Card #: ____________________

Primary Phone #: ________-________-___________ Secondary Phone #: ________-________-___________

Referral Indications

Please select all that apply and specify date where applicable:

☐ Stable Angina ☐ STEMI ☐ NSTEMI Date: ____________________

☐ PCI ☐ CABG ☐ Valve surgery ☐ PPM or ICD implant Date: ____________________

☐ Stroke/TIA Date: ____________________

☐ Heart failure ☐ Cardiomyopathy Date: ____________________

☐ Heart transplant Date: ____________________

☐ PAD Date: ____________________

☐ Other: ________________________ Date: ____________________

Known CV risk factors: ☐ Family History of CVD ☐ Diabetes ☐ Hypertension ☐ Dyslipidemia/hyperlipidemia

☐ Sleep apnea ☐ Stress/anxiety/depression ☐ Smoking ☐ Alcohol ☐ Waist Circumference/BMI

Comorbidities: ____

Notes/specific issues of concern (e.g. restrictions, contraindications):

Patient Consent

☐ Patient has provided their consent for OSMH Cardiovascular and Pulmonary Rehabilitation Program to collect health records pertaining to their care in this program.

Referring Physician Information

Referral source: ☐ Cardiologist ☐ Internist ☐ Family Physician ☐ Other: ____________________

Physician Name (please print): ____________________________________

Physician Signature: ________________________ Date:__________________

Office Telephone #: ________-________-___________ Office Fax #: ________-________-___________

Please include recent consult notes and relevant investigations (e.g. ECG, echo, stress test, lipid profile, HbA1c) if not available through ConnectingOntario or OSMH electronic medical records.