LAKERIDGE HEALTH

Cardiac Rehabilitation Referral Form

Patient Information

Last name: _____ First name: _____

Street address: _____ Gender: ☐ Male ☐ Female

City: _____ Postal code: _____ Phone no.: _____

Date of birth *(DD/MM/YY)*: _____ Health card no.: _____

Referral Indication (Require established vascular disease or 3 risk factors)

Cardiovascular History

	Year		Year		Year
☐ Cardiac admission to hospital within 1 year		☐ Angioplasty		☐ ICD	
		☐ Bypass surgery		☐ Peripheral vascular disease	
☐ Angina		☐ Congestive heart failure		☐ Non-debilitating stroke or TIA	
☐ ACS		☐ Cardiomyopathy		☐ Valve repair or replacement	
☐ MI		☐ Pacemaker			

Risk Factors

- ☐ History of smoking
- ☐ Diabetes
- ☐ Hypertension > 130/80 mmHg
- ☐ LDL cholesterol > 2.0 mmol/L
- ☐ Obesity (Waist girth: Male > 90 cm; Female > 88 cm)
- ☐ Sedentary lifestyle (Less than 90 minutes of physical activity per week)
- ☐ Major depression

Referral to cardiac rehabilitation includes referral for an exercise test for exercise prescription.

Physician signature: _____ Date: _____ Phone no.: _____

Patient Waiver

I give _____ permission to provide the Lakeridge Health Corporation cardiac rehab program with medical records or information pertaining to my cardiac rehabilitation care.

Patient signature: _____ Date: _____

Please send completed referral and any recent office and/or procedural notes.

Fax to 416–281-7098. For any other enquiries, please phone 1-855-448-5471.