Reset Form

Trillium Health Partners

CARDIOVASCULAR PREVENTION & REHABILITATION PROGRAM REFERRAL FORM

TELEPHONE: (416) 521-4068
FAX: (416) 521-4073

Patient Acct #: _____

Patient Unit #: _____

Patient Name:

_____
LAST NAME FIRST NAME MIDDLE NAME

D.O.B. _____ / _____ / _____ ☐ Male ☐ Female
YY MM DD

Ontario Health #: _____ Version: ____

Address: _____

City: _____ Postal Code: _____

Phone: (_____) _____

Cardiac History: (YY / MM / DD)

☐ Myocardial infarction (MI) _____ /_____ /_____
☐ Angioplasty (PCI) _____ /_____ /_____
☐ History of congestive heart failure _____ /_____ /_____
☐ Bypass surgery (ACB) _____ /_____ /_____
☐ Other: _____ _____ /_____ /_____

☐ Pacemaker / ICD _____ /_____ /_____
☐ Angina _____ /_____ /_____
☐ PVD _____ /_____ /_____
☐ Valve _____ /_____ /_____

Other Related History

☐ History CVA _____ /_____ /_____ ☐ Diabetes ☐ COPD
☐ Limited Arthritis / Musculoskeletal problems. Please explan: _____

_____

Current Symptoms:

☐ Angina _____ ☐ Arrhythmias _____ ☐ SOB _____ ☐ Other: _____

Most recent cardiac-related hospitalization or transfer date: (YY/ MM / DD) _____ /_____ /_____

Hospital: _____

Reason: _____

Please Include:

(a) A recent complete history
(b) A recent 12 lead ECG
(c) Angiogram results
(d) Echo results (if available) and
(e) Stress test results (if available)
(f) Procedure results
(g) Recent blood work

Referral to Cardiac Rehabilitation includes a referral for a rehabilitation stress test for assessment and exercise prescription purposes

Referring Physician Signature	Billing #	Phone #
Completed by (please print)	Date (YY / MM / DD)	

Waiver

Print Surname	Given name(s)

I hereby authorize _____
to release to Trillium Health Partners, Cardiovascular Prevention & Rehabilitation Program, any medical records or information concerning my admission(s).

Signature	Witness	Date (YY / MM / DD)

7544 D HR (February/2017)