Trillium Health Partners

CARDIOVASCULAR WELLNESS AND REHABILITATION CENTRE REFERRAL FORM

Telephone Number: (416) 521-4068
Fax Number: (416) 521-4073

Account Number: _____ Unit Number: _____

Patient First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth (MM/DD/YY): _____ ☐ Male ☐ Female

Healthcard Number: _____ Version: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____

Cardiac History

	(MM/DD/YYYY)		(MM/DD/YYYY)
☐ Myocardial Infarction (MI)	_____	☐ Pacemaker / Implantable Cardioverter-Defibrillator (ICD)	_____
☐ Angioplasty / Percutaneous Coronary Intervention (PCI)	_____	☐ Angina	_____
☐ History of Congestive Heart Failure (CHF)	_____	☐ Peripheral Vascular Disease (PVD)	_____
☐ Aortocoronary Bypass Surgery (ACB)	_____	☐ Valve	_____
☐ Other: _____	_____		

Other Related History

☐ History of Cerebrovascular Accident (CVA) Date (MM/DD/YYYY) _____

☐ Diabetes

☐ Chronic Obstructive Pulmonary Disease

☐ Limited Arthritis / Musculoskeletal problems. Please explain:

Current Symptoms

☐ Angina ☐ Arrhythmias ☐ Shortness of Breath

☐ Other _____

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

Hospital: _____

Reason:

Please Include:
(a) A recent complete history
(b) A recent 12 lead electrocardiogram (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 Name _____ Billing Number _____ Referring Physician Phone Number _____

Completed by (please print) _____ Date (MM/DD/YYYY) _____

Waiver

Print Patient's Surname _____ Given Name(s) _____

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

Patient's Signature _____ Witness' Signature _____ Date (MM/DD/YYYY) _____