Central East
REGIONAL CARDIOVASCULAR REHAB

Regional Cardiovascular Rehab Referral

Patient Information

Last name: _____ First name: _____ Gender: ☐ Male ☐ Female

Street address: _____ City: _____ Postal code: _____

Health card number: _____ Date of birth *(DD/MM/YY)*: _____

Phone number: _____ Email: _____

Indication for Referral (Established vascular disease or heart failure)

- ☐ Coronary artery disease
- ☐ Angina
- ☐ Angioplasty or Bypass surgery
- ☐ Myocardial infarction
- ☐ Admission acute coronary syndrome
- ☐ Congestive heart failure
- ☐ Cardiomyopathy
- ☐ Heart transplant
- ☐ Valve surgery
- ☐ Pacemaker/Defibrillator
- ☐ Peripheral vascular disease
- ☐ Non-debilitating stroke or TIA
- ☐ Carotid stenosis
- ☐ Renovascular disease
- ☐ Diabetes > 55yo + 2^{+} risk factors

Risk Factors

- ☐ Family history
- ☐ Diabetes
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ History of smoking
- ☐ Obesity
- ☐ Sedentary

Referral by

Referred by: _____ Date: _____

Name (print please): _____

Phone number: _____ Fax number: _____ Work email: _____

Referral to cardiovascular rehab includes a fitness assessment

Please fax completed referral test results and clinical notes to 416-281-7280.
For any other enquiries, please phone 416-281-7022 or (Toll Free) 1-855-448-5471.

gethearthealthy.ca