SOUTHLAKE
REGIONAL HEALTH CENTRE

The Magna Centre
800 Mulock Drive
Newmarket, ON L3Y 4Y9
Tel: (905) 895-4521, ext. 6411

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: (Print first, last) _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Cardiovascular Prevention and Rehabilitation Program Referral

FAX: 905-235-0685

Patient Name: (print first, last)

Contact Number: | **Alternate Number:**

Primary Care Physician Name: (if different from referring Physician) (print first, last)

Additional Copies to:

Indication for Referral:
❑ CABG ❑ CAD ❑ CHF ❑ Dysrhythmia ❑ LVAD ❑ PCI ❑ PVD ❑ TIA - Stroke ❑ Valve

Cardiac Risk Factors:
❑ Diabetes ❑ Hyperlipidemia ❑ Hypertension ❑ Physical Inactivity ❑ Smoker

Brief History:

Allergies: ❑ No Known Allergies

Current Medications:

REFER TO: ❑ **Cardiovascular Prevention and Rehabilitation Program**

Please attach:
- Hospital Discharge summary
- Cardiac Catheterization Report
- Echocardiogram Report
- Most recent ECG &/or treadmill test Report
- Lipid profile
- Holter monitor report (if applicable)

❑ **Annual Alumni Exercise Assessment**

Heart Function Clinic to Complete **– Cardio-Pulmonary Exercise Test/Assessment:** ❑ **Yes** ❑ **No**

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician: (print first, last) | **Billing #:**

Signature: | **Date:** dd / mm / yy

Phone Number: | **Fax Number:**