St.Mary's REGIONAL CARDIAC CARE CENTRE
Phone: 519- 885-9517
Fax: 519- 885-1242

Last Name First Name

Address

Home Phone Date of Birth (DD/MM/YY)

Cardiac Rehabilitation Referral Form

❑ **Post MI:**
Date: _____
❑ Thrombolytic
❑ Q Wave ❑ Non Q wave
❑ Inferior ❑ Lateral ❑ Anterior ❑ Posterior ❑ Right Ventricle

❑ **Cardiac Surgery:**
Date:_____
❑ CABG Vessel(s):_____
❑ Valve
❑ Other:_____

❑ **Coronary Angioplasty:** ❑ Stent Date:_____ Vessel(s): _____

❑ **CHF** ❑ **Unstable Angina**

❑ **Other:** (please specify) _____

Medical History

❑ Coronary Angiogram: Date: _____ Diseased Vessels: ❑ RCA ❑ LAD ❑ Circumflex
❑ Angina ❑ Peripheral Vascular Disease ❑ CHF ❑ Stroke ❑ Pacemaker
❑ Defibrillator (ICD)

LVEF

❑ Greater than 50% ❑ 35 – 49% ❑ 20 – 34% ❑ Less than 20%

Dysrhythmias

❑ Atrial dysrhythmias ❑ Isolated PVC's (<10/hr) ❑ Isolated PVC's (>10/hr)
❑ Non-sustained VT ❑ Recurrent VT ❑ Episode of VF

Heart Hazards

❑ Hypertension ❑ Dyslipidemia ❑ Family History ❑ Diabetes
❑ Inactivity ❑ Stress ❑ Smoking ❑ Obesity

Patients referred to the SMGH Cardiac Rehabilitation program will be assessed and treated by members of the multidisciplinary team dependant on the patient's needs as identified during the intake interview. Team members include the following: Registered Nurse, Cardiac Exercise Specialist, Registered Dietitian, Physician, and Physiotherapist

Referring Physician: _____ Date:_____
Print Name

_____
Signature

Please forward a consultation note, 2D Echo, lipid profile and exercise stress test summary if available.