Carefirst Community Cardiovascular Prevention & Rehabilitation Program

Located at
Bayview Hill Community Centre
114 Spadina Road,
Richmond Hill ON L4B 2Y9

T **416-502-2323 ext. 6010**

PHYSICIAN REFERRAL

Name ______________________________
Last First

☐Male ☐Female DOB _____/_____/_____
YY MM DD

Health Card # ____________________ Ver ________

Address ______________________________
(Number, Street Name, Unit)
____
(City) *(Postal Code)*

Phone (Home) ______________________
Phone (Cell) ______________________
Email ______________________

Please fax this form with appropriate documentation (listed below) to:
416 – 502 – 2382

Reason for Referral: ☐ Stroke/TIA ☐ Other cardiovascular disease ______________________
(Please indicate)

Date of Referral (YY/MM/ DD): ______ /_____ /_____

Other Related Cardiovascular History: (Year/Month/Day)

- ☐ MI _______/_____/_____
- ☐ Angioplasty _______/_____/_____
- ☐ History of congestive heart failure _______/_____/_____
- ☐ Angina _______/_____/_____
- ☐ Diabetes _______/_____/_____
- ☐ Pacemaker/ICD _______/_____/_____
- ☐ CABG _______/_____/_____
- ☐ PVD _______/_____/_____
- ☐ COPD _______/_____/_____
- ☐ Other: _______/_____/_____
- ☐ Limited Arthritis /Musculoskeletal problems. Please explain ______________________________

Current Symptoms:

☐ Angina ____________ ☐ Palpitations ____________ ☐ SOB ____________ ☐ Other: ____________

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

Hospital: ______________________________ Reason: ______________________________

Please include with this referral form:

(A) A recent complete history	☐	(D) Echocardiogram results	☐
(B) A recent 12 lead ECG	☐	(E) Stress test results	☐
(C) Recent blood test results	☐	(F) Holter monitor report	☐

Referral **includes** a referral for a cardiac stress test for assessment and exercise prescription purposes.

Referring Physician Signature	**Address** (with Postal Code)
Referring Physician Name (Please print)	**Telephone No.**
Date (YY/MM/DD)	**Fax No.**

Patient Consent to Disclose Personal Health Information

Last Name (Please Print)	**First Name** (Please Print)

I hereby authorize ______________________________ to release to Carefirst Seniors & Community Services Association and Carefirst Family Health Team, any medical records or personal health information concerning my admission(s).

Signature	**Witness**	**Date** (YY/MM/DD)

FOR INTERNAL USE

Referral Processed by: ____________________ Date: ____________________

☐ **Confirmation with Client**
☐ **Confirmation with Referring Physician**

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