TORONTO REHABILITATION INSTITUTE
CARDIAC REHABILITATION & SECONDARY PREVENTION PROGRAM

347 Rumsey Road, Toronto Ontario M4G 1R7
Tel: (416) 597-3422, ext. 5200 Fax: (416) 425-0301
www.torontorehab.com

REFERRAL FORM

PATIENT INFORMATION

NAME _____ SEX ❑M ❑F DATE OF BIRTH _____
(Please Print) Last Name First Name Middle Initial Month/Day/Year

STREET ADDRESS _____ APT # _____

CITY _____ PROV _____ POSTAL CODE _____

TEL (___) _____ (___) _____ EMAIL _____
Home Business

OCCUPATION _____ HEALTH CARD NO _____

CLOSEST RELATIVE (or CONTACT PERSON) _____ TEL (___) _____

REFERRAL DIAGNOSIS	DATE	HOSPITAL	COMMENTS
❑ MI			
❑ CABG			
❑ PTCA			
❑ Angina Pectoris			
❑ Other _____			

REFERRING PHYSICIAN INFORMATION

NAME _____
(Please Print) Last Name First Name

TEL (___) _____ FAX (___) _____ EMAIL _____

ADDRESS _____ POSTAL CODE _____

_____ ❑ Family Practice ❑ Cardiology ❑ C.V. Surgery ❑ Internist
(Physician Signature)

**** PLEASE NOTE: Attaching a12 Lead ECG and Discharge Summary will Expedite the Start of Rehabilitation**

PATIENT WAIVER

_____ _____
(Print) Last Name First Name Date Of Birth

I Hereby Authorize _____ to Release to Toronto Rehabilitation Institute any Medical Records or Information Concerning my Admission.

Dated this _____ Day of _____ 20 _____

Signature _____ Witness _____