UHN Peter Munk Cardiac Centre

Addressograph here or
Pt name, address, phone

Cardiovascular Rehabilitation & Prevention
(Chronic Disease Mgmt & Risk Reduction)
Peter Munk Cardiac Centre
REFERRAL FORM

FAX completed form to: **(416) 603-5373**

REFERRALS ***INTERNAL*** TO UHN – clinical information will be extracted from EPR. Please complete #1-8:

1. Date of Referral: _____ (dd) _____ (mmm) _____ (yyyy)

2. **I agree my patient can undergo a medically-supervised exercise stress test for the purpose of exercise prescription and triage (please check ☑ one box): ☐ Yes ☐ No**
(see below for timing considerations, *if any*):
☐ anytime after referral ☐ 2 weeks after referral ☐ 4 weeks after referral ☐ other: _____

3. **For nutrition consultation only ☐** **For Group Education only ☐**

4. Referring Physician: _____ Billing # _____
Physician signature: _____

5. Family Physician: _____ ☐ Send intake & d/c summaries to GP only

6. Referral Source: ☐ Cardiologist ☐ CV Surgery ☐ GP
☐ Internist ☐ PCI Unit ☐ Other clinic/office

7. Name of relative/contact person if limited English proficiency: _____, ☎ (____) _____

8. Interpreter required: ☐ Yes, specify language of proficiency: _____

REFERRALS ***EXTERNAL*** TO UHN – in addition to completing #1-8 above, please provide information below:

1. Please fax discharge summary, consult notes and all available cardiac / respirology investigations with referral form (i.e., EKG, echo, perfusion scan, angiogram, lipid profile), discharge medications.

2. Indication for Referral (check ☑ all that apply, and specify date where applicable):

☐ MI / ACS _____ ☐ CABG and / or valve surgery _____

☐ PCI _____ ☐ Congenital HD _____

☐ Pre/post heart or heart & lung transplant _____ ☐ Stable CHF _____

☐ PVD / PAD _____ ☐ Pacemaker, ICD, Other: _____

☐ Stroke / TIA (pt can ambulate) _____ ☐ Diabetes, with multiple cardiac risk factors

3. Known cardiac risk factors (check ☑ all that apply):

☐ Hyperlipidemia ☐ Diabetes ☐ Sedentary ☐ Psychosocial distress
☐ Hypertension ☐ Obesity ☐ Smoking

4. Please include any notes, specific issues of concern with this patient (e.g., comorbidities, restrictions, contraindications) with referral.

UHN, Toronto Western Hospital; 399 Bathurst Street, 7 Fell Wing, Room 108; Toronto, Ontario; M5T 2S8
☎: (416) 603-5200 Fax number: (416) 603-5373