UNIVERSITY OF OTTAWA HEART INSTITUTE
INSTITUT DE CARDIOLOGIE DE L'UNIVERSITÉ D'OTTAWA

REFERRAL FORM
Cardiovascular Rehabilitation Program

Return to: Fax 613-696-7106
***Please include: medication list, most recent blood work results, complete medical history, and any relevant non-invasive cardiac testing.**

Date (yyyy/mm/dd)	DOB (yyyy/mm/dd)	TOH Medical Record Number	Language ❑ English ❑ French ❑ Other ____

Last Name	First Name	Gender ❑ Male ❑ Female

Home Address	City	Postal Code

Phone Number	Other Phone Number	E-mail

Referring Physician	Health Card Number/Version Code

PLEASE DESCRIBE THE PATIENT'S CURRENT ADMISSION DIAGNOSIS/REASON FOR REFERRAL

Reason for Referral/Diagnosis	**Date** (yyyy/mm/dd)	**Reason for Referral/Diagnosis**	**Date** (yyyy/mm/dd)
❑ Myocardial Infarction: ❍ Non-STEMI ❍ STEMI		❑ Acute Coronary Syndrome	
❑ Angina		❑ Aortic surgery	
❑ Angiogram ❑ Percutaneous Coronary Intervention		❑ Cardiomyopathy	
❑ Coronary Artery Bypass Graft		❑ Cerebrovascular Disease ❍ Stroke ❍ Transient Ischemic Attack	
❑ Valve replacement ❑ Valve repair		❑ Heart Transplant	
❑ Heart Failure		❑ MitraClip ❑ Transcatheter Aortic Valve Implant	
❑ Automatic Implantable Cardioverter Defibrillator ❑ Pacemaker ❑ Left Ventricular Assist Device		❑ Pulmonary hypertension	
❑ Peripheral Vascular Disease		❑ Primary prevention	
❑ Spontaneous Coronary Artery Dissection		❑ Arrhythmia	
❑ Other			

SPECIFIC ISSUES OF CONCERN WITH THIS PATIENT

Referred by physician	Signature	Date (yyyy/mm/dd)	Time

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