STANDARDIZED POST-MI CARDIAC REHABILITATION REFERRAL FORM

Local Cardiac Rehab Centre(s): *(check box to identify the centre most convenient for the patient)*

☐ [organization], [city], [street address],[phone], [fax]

☐ [organization], [city], [street address],[phone], [fax]

☐ [organization], [city], [street address],[phone], [fax]

☐ *Other (see list attached)* ______________________________

Please see this patient to arrange cardiac rehab in follow up of their **recent MI**, which was treated at **[hospital name]** on **[removal date]**.

Patient Information:

Name: [First name] [Last name]

Street Address: [Street Address]

City: [City]

Postal Code: [Postal Code]

Phone #: [Phone #]

Sex: [male/female]

Date of Birth: *please add here*

Health Card#: *please add here*

Add Patient Contact Information Here

☐ I confirm that the above contact information is correct and the patient has authorized transfer of this information so that the cardiac rehab team may contact the patient directly

Clinical Information: (check box and add relevant information)

☐ I have ***attached*** the hospital discharge summary describing the patient's myocardial infarction

☐ I have ***not received*** the discharge summary, please accept referral based on the information here

Comorbidities, and/or limitations for exercise: *please add here*

Name (print): ______________________ CPSO number: ______________________

Signature: ______________________ Date: ______________________