STEVENSON MEMORIAL HOSPITAL

200 Fletcher Crescent PO Box 4000
Alliston, Ontario L9R 1W7
Tel: 705-434-3377
Fax: 705-434-5118
Email: cardiacrehab@smhosp.on.ca

PATIENT LABEL

CARDIOVASCULAR PREVENTION & REHABILIATION PROGRAM REFERRAL
Fax to: 705-434-5118

Name:	
Address:	
Phone:	**DOB:** (dd/mm/yy)

Indication for Referral: ☐ MI ☐ Valve ☐ PCI ☐ TIA/Stroke ☐ CABG ☐ Angina ☐ CHF ☐ Dysrhythmia ☐ PVD

Risk Factors: ☐ Diabetes ☐ Hypertension ☐ Dyslipidemia ☐ Smoker ☐ Obesity ☐ Stress ☐ Family Hx

Medical History:

Allergies:

Surgical Procedures:

Medication:

Recent Prior investigations (attach results):

☐ ECG
☐ Stress test
☐ Consult notes
☐ Echocardiogram
☐ Angiogram report
☐ Lipid Profile (last 3 months)
☐ Chest X-ray

Patients referred to SMH Cardiac rehabilitation program will be assessed and treated by members of a multidisciplinary team. Team members include: Physician, Dietitian, Registered Nurse, and Registered Kinesiologist.

Physician Name:	
Physician Signature:	**Date:** (dd/mm/yy) _____/_____/_____