HÔTEL-DIEU GRACE HEALTHCARE

Windsor-Essex Cardiac Wellness Centre

REFERRAL
CARDIAC WELLNESS PROGRAM

Referral includes Cardiac Wellness Program, Initial and Discharge Stress Test and Consult. Physician referral/signature required.

First Name: _____ Address: _____

Last Name: _____ _____

Gender: ☐ Male ☐ Female City: _____

Date of Birth: _____ (MM/DD/YYYY) Province: _____

Patient ID: _____ Postal Code: _____

H.I.N.: _____ Phone: _____

Version Code: _____ E-Mail: _____

Family Doctor: _____ Cardiologist/ Internist: _____ Surgeon: _____

Referring Clinician	☐ Family Physician ☐ Cardiologist ☐ Cardiac Surgeon ☐ Internist ☐ Nurse Practitioner ☐ Other (specify) _____ ☐ Unknown
Point of Referral	☐ Emergency ☐ Cardiac Diagnostics/Interventions ☐ Inpatient Unit ☐ Physicians Office ☐ Outpatient Clinic ☐ Other (specify) _____ ☐ Unknown
Referral Event	☐ MI ☐ PCI ☐ CABG ☐ Aortic Valve ☐ Mitral Valve ☐ Cardiomyopathy ☐ Transplant ☐ CHF ☐ Stable CAD ☐ Unstable Angina ☐ Other (specify) _____

Referral Event Date: _____ (MM/DD/YYYY) Hospitalization Required: ☐ Yes ☐ No ☐ Unknown

Please indicate cardiac rehab site and fax all pertinent discharge summaries, blood work, cardiac investigations (ECG, stress test, echo, MIBI, angio etc) along with the completed referral form.

CENTRALIZED REFERRAL – FAX TO: 519-257-5277 - Select Preferred Site
☐ HDGH: Windsor Site ☐HDGH: Leamington Site

_____ _____ _____ (MM/DD/YYYY)
Referring Physician (Print Clearly) Referring Physician Signature Date

Office Use Only: Intake Stress: _____ Discharge Stress: _____