MacCardiac Rehabilitation Program
Physician Referral Form

For completion by Referring Physician

☐ As an entry requirement of the program, I have conducted/referred my patient for a cardiopulmonary exercise test. I have reviewed the results and the patient is clear to exercise. Based on a recent review of this patient's health, I wish to refer my patient to the MacCardiac Rehabilitation Program, which includes a physiotherapy assessment, as well as aerobic and resistance exercise. Limitations at this time include: _____

_____

Certification Statement: *I have received authorization from this patient to release the information below and to permit the staff of PACE to contact him/her directly for follow-up.*

Name of Referring Physician: _____ **Date**: _____

Physician Signature: _____ **Telephone**: _____

Patient Information

Name: _____ **Diagnosis:** _____

Telephone: _____ **Date of Birth (MM/DD/YY):** _____

Please check if present:

☐ **Dyslipidemia** ☐ **Hypertension** ☐ **Diabetes** ☐ **Smoking**

☐ **Obesity** ☐ **Family Hx** ☐ **Stress** ☐ **Depression/anxiety**

Reason for Referral

Post MI: Date: _____ Q Wave: _____ Non Q Wave: _____

Location: Anterior _____ Inferior _____ Lateral _____ Posterior _____ R- Ventricle _____

Cardiac Surgery: Date: _____ CABG _____ Valve _____ Other _____

Coronary Angioplasty: Date: _____ Vessel (s) _____ Stent _____

Return to: McMaster Physical Activity Centre of Excellence (PACE)
Department of Kinesiology, McMaster University
Ivor Wynne Centre, Room E114
Phone: 905-525-9140, ext. 27223
Fax referral form to: 905-525-7629