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 MacCardiac Rehabilitation Program, which includes a physiotherapy assessment, as well as aerobic and resistance exercise.

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

Name of Referring Physician:_____ **Telephone**: _____

Physician Signature:_____ **Date:** _____

Patient Information

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

Telephone:_____ **Diagnosis:** _____

Post MI (Date): _____ ☐ Q Wave ☐ Non Q Wave

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

Cardiac Surgery (Date): _____ ☐ CABG x _____ ☐ Valve: _____ ☐ Other: _____

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

Please check if present: ☐ Dyslipidemia ☐ Hypertension ☐ Diabetes ☐ Smoking

☐ Family History ☐ Depression/anxiety ☐ Stress ☐ Obesity

Physical activity limitations include:

Please return form to:

McMaster Physical Activity Centre of Excellence (PACE)
McMaster University, Ivor Wynne Centre, Room E114
1280 Main Street West
Hamilton, Ontario L8S 4L8
Phone: 905-525-9140, ext. 27223
Fax referral form to: 905-525-7629