Carefirst Community Cardiovascular Prevention & Rehabilitation Program
Physician Referral Form

TEL: 416-847-8941
FAX: 416-847-8942

☐ **Richmond Hill Site**	☐ **Scarborough Site**
Bayview Hill Community Centre 114 Spadina Road Richmond Hill ON L4B2Y9 English – Wednesday 9:30 – 11:00am Chinese – Wednesday 1:00 – 2:30pm	Carefirst One-stop Multi-services Centre 300 Silver Star Blvd Scarborough ON M1V0G2 English – Monday 2:30 – 4:00pm Chinese – Tuesday 1:30 – 3:00pm

Patient Name: _____ ☐ Male ☐ Female
Last *First*

DOB: _____/_____/_____ **Health Card #:** _____ **Version Code:** _____
YYYY *MM* *DD*

Address: _____
Street Number *Street Name* *Unit/Apt* *City* *Postal Code*

Home Phone: _____ **Cell Phone:** _____ **Email :** _____

Language: ☐ English ☐ Cantonese ☐ Mandarin ☐ Others: _____

Reason for Referral: ☐ CAD ☐ Stroke/TIA ☐ Other: _____
☐ Prevention

Relevant Risk Factors:

☐ Hypertension ☐ Obesity ☐ Family History ☐ Other:
☐ Diabetes Mellitus ☐ Dyslipidemia ☐ Lifestyle

Please include the following with this referral form:

1) Recent complete History

2) Recent blood test results (including BG, A1C, lipid profile)

If available, please further attach reports of the following:

☐ Stress test ☐ Recent 12 lead ECG ☐ Holter monitor ☐ Echocardiogram

I agree my patient can undergo a medically-supervised exercise stress test for the purpose of exercise prescription and triage ☐ Yes ☐ No
(see below for timing considerations, if any)

☐ Any time after referral ☐ 2 weeks after referral ☐4 weeks after referral ☐other

Referring Physician Information

Name: Phone:

Address: Fax:

Billing number:

Physician Signature: _____ **Date :** _____