



Thunder Bay Regional
Health Sciences
Centre

**Cardiovascular Rehabilitation
Program
PHYSICIAN REFERRAL**

Patient Name: _____
 D.O.B. (YYYY-MM-DD): _____
 Address: _____
 City/Town, Prov: _____
 Postal Code: _____ Tel: _____
 Health Card #: _____ Version: _____
 Place Patient Label with Barcode Here

Cardiovascular Rehabilitation Booking Office:

Phone: (807) 684-6780

Fax: 1-(855)-249-4937

Guidelines:

- Physicians must complete and sign requisitions. Incomplete requisitions will be returned resulting in delay of care.
- Fax requisitions to 1-(855)-249-4937. Completed requisitions will be filed in the central referral system

PLEASE SELECT THE APPROPRIATE LOCATION FOR EXERCISE :

- | | |
|---|--|
| <input type="checkbox"/> Atikokan General Hospital | <input type="checkbox"/> Riverside Health Care Facilities Inc., LaVerendrye Site |
| <input type="checkbox"/> Dryden Regional Health Centre | <input type="checkbox"/> Sioux Lookout Meno-Ya-Win Health Centre |
| <input type="checkbox"/> Geraldton District Hospital | <input type="checkbox"/> Thunder Bay Regional Health Sciences Centre |
| <input type="checkbox"/> Manitowadge General Hospital | <input type="checkbox"/> NOSH-Wilson Memorial Hospital |
| <input type="checkbox"/> Nipigon District Memorial Hospital | <input type="checkbox"/> Ignace Mary Berglund Health Centre |
| <input type="checkbox"/> NOSH- The McCausland Hospital | <input type="checkbox"/> Red Lake Margaret Cochenour Memorial Hospital |

REFERRING EVENT:

- | | | |
|---|--|---|
| <input type="checkbox"/> Stable Coronary Artery Disease | <input type="checkbox"/> Acute Coronary Syndrome | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Coronary Artery Bypass Grafting | <input type="checkbox"/> Valve Replacement/Repair |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Other: _____ | | |

Event Date: _____ Hospital: _____

All clients referred to the Cardiovascular Rehabilitation Program may access any or all of the following services:

- Exercise Classes
- Education Sessions (Modifiable risk factor focus)
- Counseling (nutrition, psych/social, smoking cessation)

These services may be offered in person or virtually.

Comments: _____

Physician Name (print) _____ Date: _____

Physician Signature: _____

