PHYSICIAN REFERRAL FORM
FAX: (905) 378-5724

Brock-Niagara
Centre for Health & Well-Being

FOR COMPLETION BY REFERRING PHYSICIAN
Name of referring physician:
I wish to refer my patient to the Brock-Niagara Centre for Health & Well-Being for the purpose of cardiac rehabilitation, which includes exercise stress testing and aerobic and resistance training.
Certification Statement: I have received authorization from this patient to release the information below and to permit the staff of the Brock-Niagara Centre for Health & Well-Being *to contact him/her directly for follow-up.* *(Physician signature required below)*
Physician Signature: _____ **Date:** _____

PATIENT INFORMATION	
Name:	Date of Birth:
	Telephone:

REASON FOR REFERRAL - PRIMARY PREVENTION ☐			
☐ Dyslipidemia	☐ Hypertension	☐ Obesity	☐ Diabetes

REASON FOR REFERRAL – SECONDARY PREVENTION ☐						
☐ **Post MI:** Date:			☐	☐ Wave	Non Q	
	Location:	☐ Anterior	☐ Inferior	☐ Lateral	☐ Posterior	☐ Rt. Vent
☐ **Cardiac Surgery**: Date:			☐ CABG	☐ Valve	☐ Other _____	
☐ **Coronary Angioplasty:** Date:				Vessel (s):	☐ Stent	

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