Brockville General Hospital

CARDIAC REHABILITATION PROGRAM REFERRAL FORM

PHONE NUMBER: 613-345-5649 ext. 51272

As of February 2025

INSTRUCTIONS

- **Please print the form, complete it and fax to the clinic at 613-345-8348.**
- **Please include copies of cath reports, most recent EST, recent echo, hospital discharge summary and pertinent consultation reports.**

PART A – PATIENT INFORMATION

PATIENT LAST NAME: _____ **FIRST NAME:** _____

DATE OF BIRTH (YYYY/MM/DD): _____/____/____

HEALTH CARD NUMBER: _____ **VC:** _____

ADDRESS: _____

_____

CONTACT NUMBER: _____

PART B – RISK STRATIFICATION (where does this patient fit?)

LVEF (Include if available): _____

☐ Low Risk	☐ Intermediate Risk	☐ High Risk
• EF greater than or equal to 50% • Uncomplicated event • Functional capacity (over 7 METS) • No ischemia • No complex arrythmia	• EF 31 – 49% • FC 5-6.9 METS	• EF less than 30% • FC less than 5 METS • MI complicated by CHF, shock, and/or complex ventricular arrythmia without complete revascularization • Cardiac arrest • Abnormal hemodynamics with exercise (e.g. BP drops) • Clinically significant depression • Complex arrythmia • FC 5 – 6.9 METS

PART C – CLINICAL INFORMATION

Most Recent Event: ☐ Primary PCI ☐ PCI ☐ PVD ☐ MI ☐ Valve
☐ Unstable Angina ☐ CHF ☐ Cardiac Transplant ☐ CABG

Complications Post Event: _____

PART D – RELEVANT MEDICAL HISTORY

☐ Diabetes ☐ PVD ☐ Renal Failure ☐ Stroke ☐ OSA ☐ Dyslipidemia

☐ Other (please specify): _____

Special Considerations: _____

Return to Work Status: _____

PART E – REFERRAL INFORMATION

Referring Physician (please print): _____

Referral Initiated By (please print): _____

DATE (YYYY/MM/DD): _____/____/____