UNIVERSITY OF OTTAWA
HEART INSTITUTE
INSTITUT DE CARDIOLOGIE
DE L'UNIVERSITÉ D'OTTAWA

REFERRAL FORM
Division of Prevention and Rehabilitation

Return to: Fax (613) 696-7106
Prevention & Rehabilitation Centre
40 Ruskin Street, Ottawa, ON K1Y 4W7 Phone (613) 696-7068

Date (yyyy/mm/dd)	DOB (yyyy/mm/dd)	TOH Medical Record Number	Language ❑ English ❑ French ❑ Other _____

Last Name	First Name	Gender ❑ Male ❑ Female

Home Address	City	Postal Code

Phone Number	Other Phone Number	E-mail

Referring Physician	Health Card Number/Version Code

PLEASE DESCRIBE THE PATIENT'S CURRENT ADMISSION DIAGNOSIS/REASON FOR REFERRAL

Reason for Referral/Diagnosis	Date (yyyy/mm/dd)	Reason for Referral/Diagnosis	Date (yyyy/mm/dd)
❑ Myocardial Infarction ❑ Non-STEMI ❑ STEMI		❑ Acute Coronary Syndrome	
❑ Angina		❑ Aortic surgery	
❑ Angiogram ❑ Percutaneous Coronary Intervention		❑ Cardiomyopathy	
❑ Coronary Artery Bypass Graft		❑ Cerebrovascular Disease – Stroke / Trans Ischemic Attack	
❑ Valve replacement ❑ Valve repair		❑ Heart Transplant	
❑ Congestive Heart Failure		❑ MitraClip / Transcatheter Aortic Valve Implant	
❑ Automatic Implantable Cardioverter Defibrillator / Pacemaker / Left Ventricular Assist Device		❑ Pulmonary hypertension	
❑ Peripheral Vascular Disease		❑ Primary prevention	
❑ Spontaneous Coronary Artery Dissection		❑ Arrhythmia	
❑ Other			

SPECIFIC ISSUES OF CONCERN WITH THIS PATIENT

Referred by physician	Signature	Date (yyyy/mm/dd)	Time