



TORONTO REHABILITATION INSTITUTE
CARDIAC REHABILITATION & SECONDARY PREVENTION PROGRAM

347 Rumsey Road, Toronto Ontario M4G 1R7
Tel: (416) 597-3422, ext. 5200 Fax: (416) 425-0301
www.torontorehab.com

REFERRAL FORM

PATIENT INFORMATION

NAME (Please Print) Last Name First Name Middle Initial SEX M F DATE OF BIRTH Month/Day/Year

STREET ADDRESS APT #

CITY PROV POSTAL CODE

TEL Home Business EMAIL

OCCUPATION HEALTH CARD NO

CLOSEST RELATIVE (or CONTACT PERSON) TEL

Table with 4 columns: REFERRAL DIAGNOSIS, DATE, HOSPITAL, COMMENTS. Includes checkboxes for MI, CABG, PTCA, Angina Pectoris, and Other.

REFERRING PHYSICIAN INFORMATION

NAME (Please Print) Last Name First Name

TEL FAX EMAIL

ADDRESS POSTAL CODE

Family Practice Cardiology C.V. Surgery Internist

(Physician Signature)

** PLEASE NOTE: Attaching a12 Lead ECG and Discharge Summary will Expedite the Start of Rehabilitation

PATIENT WAIVER

(Print) Last Name First Name Date Of Birth

I Hereby Authorize to Release to Toronto Rehabilitation Institute any Medical Records or Information Concerning my Admission.

Dated this Day of 20

Signature Witness