



Toronto Rehab
*Advancing Rehabilitation
 Enhancing Quality of Life*

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

STREET ADDRESS _____ APT # _____

CITY _____ PROV _____ POSTAL CODE _____

TEL () _____ () _____ EMAIL _____
 Home Business

OCCUPATION _____ HEALTH CARD NO _____

CLOSEST RELATIVE (or CONTACT PERSON) _____ TEL () _____

REFERRAL DIAGNOSIS	DATE	HOSPITAL	COMMENTS
<input type="checkbox"/> MI	_____	_____	_____
<input type="checkbox"/> CABG	_____	_____	_____
<input type="checkbox"/> PTCA	_____	_____	_____
<input type="checkbox"/> Angina Pectoris	_____	_____	_____
<input type="checkbox"/> 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 _____