ST JOSEPH'S HEALTH CARE LONDON

**Referral form**

# Cardiac Rehabilitation and Secondary Prevention Ontario Health West Region

| | |
|---|---|
| Patient Name: | |
| Address: | |
| City: | Telephone: |
| D.O.B.: (YYYY/MM/DD) | Health Card Number: |

## REFERRING PHYSICIAN INFORMATION:

Name (please print):_____ Phone Number: _____

Address: _____ Fax Number: _____

Physician Signature: _____ Referral Date: _____

| | | | |
|---|---|---|---|
| **Acute Coronary Syndrome:** | ☐ STEMI | ☐ Non-STEMI | ☐ Unstable Angina |
| **Other Cardiac Events:** | ☐ PCI | ☐ AV Surgery | ☐ Transplant |
| | ☐ CABG | ☐ MV Surgery | ☐ CHF |
| | ☐ Stable Angina | ☐ Other *(specify):* | |

## PLEASE FAX YOUR REFERRAL TO:

☐ St. Joseph's Health Care London
519-667-6532

☐ Windsor Regional Hospital
519-257-5277

☐ Maitland Valley Health Team
(Goderich)
519-524-5225

☐ Alexandra Hospital Ingersoll
519-485-9615

☐ Grey-Bruce Health Services
(Owen Sound)
519-376-2063

☐ Grand Bend Community Health Centre
1-855-946-1793

☐ North Lambton Community Health Centre
(Sarnia)
519-491-6575

☐ Chatham-Kent Community Health Centre
(Chatham)
519-627-8652

☐ St. Mary's General Hospital
(Kitchener-Waterloo)
226-806-5912

Notes: _____

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**Please attach any relevant consult/ test results if not available on Clinical Connect/ OLIS**