

# REQUISITION FORM

## YORK CENTRAL HOSPITAL -WELLNESS CENTRE CARDIAC REHABILITATION CENTRE

955 Major Mackenzie Drive, Vaughan, Ontario, L6A 4P9  
3<sup>rd</sup> Floor  
Tel: (905) 832-8070 x.2232  
Fax: (905) 832-0720

NAME:

PHONE#

D.O.B.:

H.C. #:

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**DIAGNOSIS:**

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**SURGICAL PROCEDURES:**

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**CONTRAINDICATIONS-RESTRICTIONS:**

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**TREATMENT – CARDIAC REHABILITATION CENTRE** (please forward any recent test results)

FULL PARTICIPATION (Exercise Class, Education, P/T, O/T, Dietitian, Pharmacist, Social Worker Consult)

LIMITED PARTICIPATION (No Exercise Class Included)

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**REMARKS:**

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PHYSICIAN NAME

DATE

SIGNATURE OF REFERRING PHYSICIAN

**DEAR PHYSICIAN,**

Please ensure before referring the patient to the YCH-CRC that the following tests are sent:

Most recent consult note	Echocardiogram
Stress test / Sestamibi or Stress Echo.	Blood screen/Lipid profile within last 3 mos.
Rest ECG/Exercise ECG	Angiogram report