Mackenzie Health

Chronic Disease Wellness Centre
955 Major Mackenzie Drive West, 3rd Floor Suite 340
Vaughan, Ontario, L6A 4P9
Tel: 905-883-2211
Fax: 905-883-0772

NAME: _____

PHONE#: _____

D.O.B.: _____

H.C. #: _____

Cardiovascular, Pulmonary & Stroke Rehabilitation

Primary Reason for Referral:

☐ Cardiac* _____

☐ Pulmonary _____

☐ Stroke within last 6 months with deficits, Date of stroke:_____

- ☐ Stroke Rehab (recommended)
- ☐ CVPR Rehab*

☐ Risk of stroke or stroke more than 6 months ago

- ☐ CVPR Rehab*

☐ Lifestyle/Risk Reduction* _____

*Referral **includes** an **initial and 6-month Functional Exercise Stress Test order**, if appropriate, for the purpose of developing the Exercise Prescription.

Please attach any pertinent notes not available in the Mackenzie Health EMR.

Reason for Referral/Diagnosis/PLEASE SPECIFY REHAB GOALS AND INCLUDE NOTES TO SUPPORT Comments:

Referring Physician (print)	Office Phone #	Date (dd/mm/yyyy)	Referring Physician Signature

0511

Please fax referral to: (905) 883-0772