



Hôpital Montfort

713 Montréal Rd., Ottawa, ON, K1K 0T1

☎ 613-746-4621 ext. 4125

Fax : 613-748-4913

Cardiovascular and Pulmonary Health Services

OUTPATIENT - REFERRAL

Name:

Surname :

Sex :

Date of birth :

Address :

Main phone number :

Other phone number :

Ontario Health Card number :

Expiration date :

Referral for PULMONARY REHABILITATION due to a diagnosis of :

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchiectasis |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> COPD (<i>Chronic Obstructive Pulmonary Disease</i>) |
| <input type="checkbox"/> Autres : _____ | |

Referral for CARDIAC REHABILITATION due to a diagnosis of :

- | | |
|--|--|
| <input type="checkbox"/> STEMI | <input type="checkbox"/> NSTEMI (<i>Acute Coronary Syndrome</i>) |
| <input type="checkbox"/> Stable Angina | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Coronary Artery Bypass (x _____) |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Heart Transplant |
| <input type="checkbox"/> Valve Replacement / Repair | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Automatic Internal cardioverter-defibrillator (<i>AICD</i>) | |

Other pertinent medical condition :

In order to accelerate the referring process, please include (if available) :

-Summary (*Hospital Discharge, Consultations, Laboratory Tests*)

-Cardiac Reports (*Angiogram, Coronary Artery Bypass Report, Echocardiogram, Stress Test*)

-Pulmonary Reports (*Complete Pulmonary Function Test, Simple Spirometry*)

Referring physician's signature: _____

CPSO #: _____ Billing # : _____ Date : _____