WRHN
Waterloo Regional Health Network

Cardiac Rehab Program
Tel: 226-806-5911
Fax: 226-806-5912

Last Name, First Name _____ Date of Birth (DD/MM/YY) _____

Address _____

Health Card Number _____ Home Phone _____

*Please include relevant clinical notes and investigations (e.g. coronary angiogram, stress test, echocardiograms, CV operative notes, hospital admission/discharge summaries and/or office consult notes. **NOTE: Referrals received without appropriate and sufficient accompanying clinical documents will not be processed.**

Cardiac Rehabilitation Referral Form

Indications (select all that apply):

❒ Coronary artery disease (e.g. prior MI/PCI/CABG, stable angina)

❒ Heart Failure/Cardiomyopathy

❒ Valvular Disease/Aortic Disease

❒ Peripheral Arterial Disease

❒ Arrhythmia (e.g. highly symptomatic Afib/flutter, prior VT/VF)

Referring Physician _____ **Date** _____
Print Name

_____ **Fax** _____
Signature

For Office Use Only

Date of Stress Test _____

Rescheduled _____

Revised October 2025