



Cardiovascular Surgical Referral Form for Elective Patients

Please fill out this form and fax to: 416-340-4811

Use CCN Referral Process

PATIENT INFORMATION

Name: _____
Surname First Name

Male Female DOB ____/____/____

Ontario Health # _____

Address _____

Postal Code _____ Phone () _____

PATIENT WAIT LOCATION: _____
(if different from above)

PHONE NUMBER: () _____

NOTES:

Translator Required: No Yes _____
(LANGUAGE)

REFERRING PHYSICIAN INFORMATION

Name: _____

Phone Number : (____) _____

E-mail: _____

PROCEDURE REQUIRED:

- | | |
|---|--|
| <input type="checkbox"/> Aortic Operation | <input type="checkbox"/> CHF Surgery |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Congenital/Myectomy |
| <input type="checkbox"/> Valve | <input type="checkbox"/> Other |

UHN CARDIOLOGY REFERRAL

Preferred Surgeon (optional): _____

UHN OFFICE USE ONLY

Surgical Accept Date: ____/____/____

Referral Date: ____/____/____

Booking Date: ____/____/____

Admission Date: ____/____/____

Transfer Date: ____/____/____

Discharge Date: ____/____/____

To contact the PMCC Triage Office, please phone 416-340-4474

PMCC Triage Office will contact you for more details as required