Coronary Angiogram Referral Form

Fax patient referral to **416-340-3788**

**** Referral must include: bloodwork within 90 days, 12-lead ECG, consult, medication list ****

First Name:	Middle Name:	Last Name:

Heath Card Number:	Auth. Issuing:	DOB: YYYY-MM-DD	MRN:

Street Address:	Suite:	City:	Prov./State:

Postal/Zip Code:	Country: If outside Canada	Primary Phone:	Alternate Phone:

Race: Race is self-identified by the patient. Patient may identify as one or more option.

☐ Black ☐ East/Southeast Asian ☐ Indigenous (First Nations, Métis, Inuk/Inuit) ☐ Latino ☐ Middle Eastern ☐ South Asian ☐ White ☐ Other

The following options cannot be indicated with any other option: ☐ Unknown ☐ Prefer Not to Answer ☐ Not Collected

Translator required: ☐ Yes ☐ No Language:_____

Referral Information

Referring Physician: **Requested Physician:**

Referring Fax #: ☐ **or 1st Available**

URGENCY (estimate from Referring Physician) – Select only 1

☐ Emergent ☐ Urgent (while still in hospital) ☐ Urgent (within 2 wks) ☐ Elective

Referring Physician Signature:	Date of Request: YYYY-MM-DD

Wait Location: Indicate Hospital name OR select a location

☐ **Home** ☐ **Rehabilitation Facility** ☐ **Medical Facility Outside of Province** ☐ **Medical Facility Outside of Country**

☐ **Hospital** _____ ☐ **Unit** _____

Reasons for Referral: Primary reason for the patient's referral is required. Indicate the appropriate reason by adding a P beside your selection to indicate Primary Reason for Referral, and S, if applicable, to indicate one Secondary Reason for Referral.

	Coronary Disease:		**Arrhythmia:**		**Cardiomyopathy**
__	Stable Angina (or Equivalent)	__	Atrial Flutter	__	**Congenital/Structural**
__	Unstable Angina (or Equivalent)	__	Atypical Atrial Flutter	__	**Heart Failure**
__	Non-ST-Segment Elevation Myocardial Infarction (NSTEMI)	__	Atrioventricular Nodal Re-entrant Tachycardia (AVNRT)	**Heart Transplant:**	
__	ST-Segment Elevation Myocardial Infarction (STEMI)	__	Atrial Tachycardia	__	Donor
		__	Paroxysmal Atrial Fibrillation	__	Recipient
	Valve Disease:	__	Persistent Atrial Fibrillation	**Other:**	
__	Aortic Regurgitation ☐ ECHO Report Attached	__	Ventricular Fibrillation	__	Syncope
__	Aortic Stenosis	__	Ventricular Tachycardia	__	Protocol (Research/Employment)
__	Other Valvular	__	Wolff-Parkinson-White Syndrome	__	Heart Disease of Other Etiology: _____
			☐ **Reports Attached**		

Special Instructions and/or /Brief Summary: *(Please include any cardiac tests that patient had done if available)*

☐ Consult Report Attached

(See next page)

Coronary Angiogram Referral Form

Fax patient referral to **416-340-3788**

**** Referral must include: bloodwork within 90 days, 12-lead ECG, consult, medication list ****

Diagnostic Information

History of Myocardial Infarction:
☐ Recent (≤30 days) ☐ History (>30 days) ☐ No

Height: (cm)
_____

History of CABG Surgery: ☐ Yes ☐ No
LIMA ☐ Yes ☐ No

Serum Creatinine:_____ µmol/L
Hgb:_____ g/L

Weight: (kg)
_____

☐ **Hx/Consult Report Attached**

Canadian Cardiovascular Society Classification:
☐ 0 ☐ I ☐ II ☐ III ☐ IV

Acute Coronary Syndrome Classification:
☐ Low Risk ☐ Intermediate Risk
☐ High Risk ☐ Emergent

☐ **Cardiogenic Shock** ☐ Yes ☐ No

Exercise ECG Risk:
☐ Low Risk
☐ High Risk
☐ Uninterpretable
☐ Not Done
☐ Reports Attached

Rest ECG Ischemic Changes:
☐ Persistent (Fixed)
☐ Transient without Pain
☐ Transient with Pain
☐ Uninterpretable
☐ Not Done
☐ Reports Attached

Functional Imaging Risk:
☐ Low Risk
☐ High Risk
☐ Uninterpretable
☐ Not Done
☐ Reports Attached

LV Function Findings:
☐ I (>=50%)
☐ II (35-49%)
☐ III (20-34%)
☐ IV (<20%)
LV Function Percentage _____%
☐ **ECHO Report Attached**

Comorbidity Assessment

Dialysis ☐ No ☐ Yes

Renal Disease ☐ No ☐ Yes

Diabetes ☐ No ☐ Yes → ☐ Insulin ☐ Oral

History of Smoking ☐ Never ☐ Current ☐ Former ☐ Unknown

Hypertension ☐ No ☐ Yes

Hyperlipidemia ☐ No ☐ Yes

Cerebral Vascular Disease (CVD) ☐ No ☐ Yes

Peripheral Vascular Disease (PVD) ☐ No ☐ Yes

COPD ☐ No ☐ Yes

Previous PCI ☐ No ☐ Yes → Date of previous PCI (YYYY-MM-DD):_____

Anticoagulant ☐ No ☐ Yes → ☐ Coumadin ☐ Heparin ☐ LMWH ☐ Dabigatran ☐ Other _____

Anticoagulant ☐ Hold ☐ Bridge

Dye Allergy ☐ No ☐ Yes

Possible Intracardiac Thrombus ☐ No ☐ Yes

ASA 81mg/od ☐ No ☐ Yes

Other Factors

☐ Other Clinical Factors ☐ Non-clinical Factors

History of Congestive Heart Failure:
☐ Yes ☐ No

Heart Failure Class (NYHA)

☐ I ☐ II ☐ III ☐ IV