

REFERRAL FORM FOR CARDIOLOGY CONSULTS

We look forward to scheduling your patient. Please **PRINT** all information and fax recent test results relevant to this consult if completed outside of UHN.

REFERRAL INFORMATION:

Referred by: _____ Billing #: _____

Phone: _____ Fax: _____

Preference for Referral: TGH Cardiology TWH Cardiology Either Site, First Available.

PATIENT INFORMATION:

If UHN Referral:

Patient's Name: _____ UHN MRN #: _____
(Please Print)

If NOT UHN Referral:

Patient's Name: _____ Date of Birth: _____
(Please Print)

Address: _____

Home Phone: _____ Other Contact #: _____

OHIP # _____

Clinical Information Relevant to the Request for Consultation:

Urgent: _____ **Next Available** _____

Current Medications:

Fax: 416-340-4127 Peter Munk Cardiac Centre Ambulatory Clinics at Toronto General Hospital: 416-340-5309

OR

Fax: 416-603-5274 Peter Munk Cardiac Centre Ambulatory Clinics at Toronto at Toronto Western Hospital: 416-603-5268