



## Peter Munk Cardiac Centre

Toronto General Hospital

### PATIENT INFORMATION - PLEASE COMPLETE

Patient name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

DOB: \_\_\_\_\_

Health card #: \_\_\_\_\_

### CV Surgery Triage Office

Phone: (416) 340-4474

Fax: (416) 340- 4811

Email : [triage-cardiacuhn-cvsurgery@uhn.ca](mailto:triage-cardiacuhn-cvsurgery@uhn.ca)

### REASON FOR REFERRAL

- ☐ Aortic valve disease
- ☐ Mitral valve disease
- ☐ Coronary artery disease
- ☐ Aortic Aneurysm
- ☐ Other \_\_\_\_\_

### URGENCY

- \_\_\_ Inpatient
- \_\_\_ Urgent Outpatient
- \_\_\_ Elective Outpatient

Referred to : \_\_\_\_\_ or \_\_\_\_\_ On Call Surgeon

Please note that you will be contacted by either the triage office or the CV Surgeon's office for more details including available investigations, bloodwork and imaging OR include the full referral note.

Referring Physician \_\_\_\_\_ OHIP Billing # \_\_\_\_\_

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_

Date of Referral \_\_\_\_\_

**Please fax or scan referral to the number or email above**