REFERRAL FORM FOR CARDIOLOGY CONSULTS –

Hypertrophic Cardiomyopathy Clinic

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: _____ (Please Print) Billing #: _____

Phone: _____ Fax: _____

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

PATIENT INFORMATION:

If UHN Referral:

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

If NOT UHN Referral:

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

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