

**TWH GIM Hypertension Clinic (General Internal Medicine)****Referral Form****Clinic information:**

- Toronto Western Hospital, 399 Bathurst Street, University Health Network, West Wing, 2<sup>nd</sup> floor
- Tel: 416 603-5853 Fax: 416 603-5987 E-mail: [TWHgimclinics@uhn.ca](mailto:TWHgimclinics@uhn.ca)
- Referral criteria (**check at least one**):
  - Age < 40 with suspected or new-onset hypertension
  - Resistant hypertension despite maximal doses of 3 or more first-line medications
  - Secondary cause (endocrine or renovascular) suspected with positive screening test or high clinical suspicion
  - Labile blood pressure
  - Orthostatic hypotension
  - White coat or masked hypertension suspected
- Exclusion criteria (**please do not refer patients with these conditions**):
  - Chronic kidney disease, stage 4 or 5 (GFR less than 30 mL/min) or renal transplant
  - Requests for 24-hour ambulatory BP monitor only. *We do not provide 24 hr ABPM as a standalone service; referring provider should order the test via a private lab such as LifeLabs or DynaCare*
  - Pregnancy-related hypertension
  - POTS (postural orthostatic tachycardia syndrome)
  - Diagnosis of hypertension only (unless meeting another criterion above). *Referring providers should follow the Hypertension Canada algorithm for diagnosing hypertension.*
  - Referrals for inpatients. *Referrals must originate from an outpatient clinic (e.g. post-discharge clinic)*
- We are a group practice; patients will be scheduled with first available physician for consults and follow-up
- We do not provide longitudinal care for patients with hypertension; patients will be limited to up to 3 visits in the clinic. Our physicians provide recommendations for implementation by the referring provider.
- For referrals not meeting the above criteria, referring providers can consider requesting an e-consult (*navigate to [otnhub.ca](http://otnhub.ca), login, then search for "Hypertension e-consult faculty group"*)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

OHIP Number or MRN: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Communication:**  Fluent in English  Will bring translator  Interpreter needed: \_\_\_\_\_**Reason for Referral:**  Meets  $\geq 1$  referral criteria above (check the box above) and no exclusion criteria**Additional details (optional):**

\_\_\_\_\_

\_\_\_\_\_

**Antihypertensive medications (list or attach):**

\_\_\_\_\_

 Additional documentation attached

Phone (Referring provider): \_\_\_\_\_ Fax (Referring provider): \_\_\_\_\_

Referring provider \_\_\_\_\_ Billing# \_\_\_\_\_ Signature \_\_\_\_\_

Date of referral: \_\_\_\_\_