Minimally Invasive Cardiac Surgery Clinic Referral Form

Toronto General Hospital, Peter Munk Cardiac Centre
200 Elizabeth Street, 4N-474, Toronto, ON M5G 2C4
Tel: 416-340-4513 Fax: 416-340-5317

UHN Peter Munk Cardiac Centre

Patient Information:			
Name:			OHIP:
DOB:	Age:	Sex:	Phone:
Address:			

Procedure Required:	Requested Imaging:
☐ CABG – Please choose: ☐ MID CAB (Single-Vessel) ☐ MICS CABG (Multi-Vessel) ☐ Mitral Valve Repair/Replacement ☐ Aortic Valve Repair/Replacement ☐ Aortic Valve Sparing ☐ Aortic Root Replacement ☐ Ascending Aorta/Arch Replacement	☐ Coronary Angiogram – Date: _____ ☐ Echocardiogram – Date: _____ ☐ Chest X-Ray – Date: _____ Please have your patient bring links or CD's of their imaging if available.

Additional Information:

Referring Physician:		
Name:	Billing:	CPSO:
Practitioner Address:	Telephone:	
	Fax:	
Practitioner Signature:	Date of Referral:	

Please fax the completed referral including clinical notes, tests, and other relevant results to **416-340-5317**.

Our clinic will contact your patient directly with an appointment.