



CATH REFERRAL		Pt Name:
DATE OF REQUEST (DOR):	-	Pt Name:
Date Format YYYY-MM-DD IMPORTANT: No	otify CATH centre of any change in the patient's cond	dition LPP Address
PHYSICIAN DETAILS		
NAME of Referring Physician	Type Specialist Family/GP	City/Town: Province: Postal Code:
	Referring MD is out-of-province	E-mail Contact:
NAME of GP/Family Physician (if different from Refe	rring) Date of Request for Specialist Consi	City/Town: Province: Postal Code:
THAT I OF OF TRAINING THE PROPERTY OF THE PROP		Health Card Number:
	Date Format YYYY-MM-DD	For Coordinator Use ONLY
NAME of Requested Procedural Physician(s)		RMWT URS WAIT
	or 1st Available	Referral Date: Acceptance Date:
PRIMARY REASON FOR REFERRAL	SECONDARY REASON	Inpt Admit Date: — — Booking Date: — —
Coronary Disease (CAD)	rtic Stenosis Heart Failure	Transfer Date: — — Discharge Date: — —
	lve area cm ² Congenital	Scheduling Details Date Format YYYY-MM-DD
	adient mmHg Arrhythmia ^{Specif}	DART to
Rule Out CAD	ner Valvular Cardiomyopathy	CANCELLATION
Other: Research Biopsy	Other Specify	MEDICAL DELAY — —
REQUEST TYPE		FAX CATH Report to:
Referral for CATH and consultation regarding subsequent management	No consult required – CATH only	Person/Organization:
URGENCY (estimate from Referring Physician)	(select 1 only)	Fax Number: E-mail: SPECIAL INSTRUCTIONS and/or BRIEF HISTORY
Emergent Urgent (while still in hospital)	Urgent (within 2 wks)	re e
PATIENT WAIT LOCATION Hospital: Specify		
Home ICU/CCU Ward: Specify	Other: Specify	
Translator Required? No Yes:	Language	Previous CATH done outside of Ontario
RECENT or PREVIOUS MI CCS/ACS ANGINA CLASS		
No Yes 1-3 Months >3-6 Months >6-12 Months >1	Year Unknown Stable CA	
Recent MI No Yes Date:		I III III IV Low Risk (IV-A) Intermediate Risk (IV-B) High Risk (IV-C) Emergent (IV-D)
(Within 30 Days)	Date:	Hemodynamically unstable (i.e., requires inotropic or vasopressor or balloon pump)
HEART FAILURE CLASS (NYHA)	COMORBIDITY ASSESSMENT	
I II III IV Not applicable	Creatinine µmol/L	Known Pending Not done
REST ECG Done Not done	Dialysis Diabetes	No Yes Diet Insulin Oral Hypoglycemics No Treatment
Ischemic changes at rest?	History of Smoking	Never Current Former Unknown
Yes No Uninterpretable	Hypertension	No Yes
Type: Not applicable Persistent	Hyperlipidemia (CVP)	No Yes
Transient w/ pain Transient w/o pain	Cerebral Vascular Disease (CVD) Peripheral Vascular Disease (PVD)	No Yes Unknown No Yes
EXERCISE ECG Done Not done	COPD	No Yes *** Provide separate documentation of previous number and location of graft:
Risk: Not applicable Low High Uninterpretable	Previous (CABG) Bypass Surgery LIMA	No Yes Prev CABG Date
	Previous PCI	No Yes Prev PCI Date — —
FUNCTIONAL IMAGING Done Not done	Anticoagulant	No Yes
Risk: Low High Not applicable	On IIIh /IIIn Inhibitara	Coumadin Heparin LMWH Dabigatran If Other No Yes
LV FUNCTION Done Not done Method:	On IIb/IIIa Inhibitors Dye Allergy	No Yes Unknown
Other ECHO MUGA Ventriculogram		No Yes Unknown
Findings: I(>=50%) II(35–49%) III(20–34%) IV(<20%	Infective Endocarditis	No Yes Active Endocarditis No Yes
Not applicable	Congenital Heart Disease History of CHF	No Yes
LV Function Percentage: %	Ethnicity	White Aboriginal South Asian Asian Black Other Unknown
Date of EF Assessment: Unknown < 1 Month 1-3 Months >3-6 Months 6+ Months		Height cm Weight kg
OTHER FACTORS affecting prioritization	PATIENT OPTIONS for Timely A	ccess to Care
Other clinical factors Non-clinical factors		with this patient (and/or significant others) timely access to care options for this procedure.
	MD SIGNATURE	Date (YYYY-MM-DD):