



Please fax the referral to 416-469-6443

| CATH REFERRAL | | Pt Name: |
|--|--|---|
| DATE OF REQUEST (DOR): | | DOB:/ / MRN/Hospital Chart #: |
| Date Format YYYY-MM-DD | IMPORTANT: Notify CATH centre of any change in the patient's con | |
| PHYSICIAN DETAILS | | |
| NAME of Referring Physician | Туре | City/Town: Province: Postal Code: |
| | Specialist Family/GP Referring MD is out-of-province | E-mail Contact: |
| | _ | Home Phone #: Other Contact #: |
| NAME of GP/Family Physician (if different | ent from Referring) Date of Request for Specialist Cons | sult by Health Card Number: |
| | | |
| NAME of Requested Procedural Physic | Date Format YYYY-MM-DI | For Coordinator Use ONLY RMWT URS WAIT |
| TANTE OF REQUESTED F TOCCULAR F HYSIC | or 1st Available | Referral Date: – – Acceptance Date: – – |
| | | Inpt Admit Date: Booking Date: |
| PRIMARY REASON FOR REFERE | | Transfer Date: – Discharge Date: – – |
| Coronary Disease (CAD) Stable CAD Unstable Angina | Aortic Stenosis Heart Failure | Scheduling Details Date Format YYYY-MM-DD |
| STEMI NSTEMI | Echo gradient mmHa | |
| Rule Out CAD | Arrhythmia Speci | |
| Other: | Other Valvular Cardiomyopathy | CANCELLATION |
| 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: Fax Number: E-mail: |
| URGENCY (estimate from Referring | g Physician) (select 1 only) | Fax Number: E-mail: SPECIAL INSTRUCTIONS and/or BRIEF HISTORY |
| | | |
| Emergent Urgent (while still | in hospital) Urgent (within 2 wks) Electi | ve |
| PATIENT WAIT LOCATION | Hospital: Specify | |
| Home ICU/CCU Ward: | Specify Other: Specify | |
| Tione 1co/cco ward. | Ottler. Specify | _ |
| Translator Required? No | Yes: Language | Previous CATH done outside of Ontario |
| RECENT or PREVIOUS MI | CCS/ACS | ANGINA CLASS |
| History of MI No Yes | Stable C | AD Acute Coronary Syndrome (ACS) |
| 1-3 Months >3-6 Months >6-12 M | lonths >1 Year Unknown 0 | I II III IV Low Risk (IV-A) Intermediate Risk (IV-B) |
| | Date: | High Risk (IV-C) Emergent (IV-D) |
| (Within 30 Days) | Date: Date: | Hemodynamically unstable (i.e., requires inotropic or vasopressor or balloon pump) |
| HEART FAILURE CLASS (NYHA) | COMORBIDITY ASSESSMENT | |
| I II III III IV N | lot applicable | Known Pending Not done |
| REST ECG Done | Not done Diabetes | No Yes Diet Insulin Oral Hypoglycemics No Treatment |
| Ischemic changes at rest? | | Never Current Former Unknown |
| Yes No Unint | History of Smoking Hypertension | No Yes |
| Type: Not applicable Persis | Hyperlipidemia | No Yes |
| Transient w/ pain Trans | Sient w/o pain Cerebral Vascular Disease (CVD) | No Yes Unknown |
| EXERCISE ECG Done | Not done Peripheral Vascular Disease (PVD) COPD | No Yes |
| Risk: Not applicable | Previous (CABG) Bypass Surgery | No Yes Provide separate documentation of previous number and location of gra |
| Low High Unir | nterpretable LIMA | No Yes Prev CABG Date |
| FUNCTIONAL IMAGING Done | Previous PCI Not done Anticongulant | No |
| | applicable Anticoagulant | Coumadin Heparin LMWH Dabigatran If Other |
| | ot done On IIb/IIIa Inhibitors | No Yes |
| Method: | Dye Allergy | No Yes Unknown |
| | /entriculogram Possible Intracardiac Thrombus | No Yes Unknown |
| Findings: I(>=50%) II(35–49%) III(20–34%) | Infective Endocarditis | No Yes Active Endocarditis No Yes |
| Not applicable | Congenital Heart Disease | No Yes |
| LV Function Percentage: | % History of CHF | White Aboriginal South Asian Black Other Unknown |
| Date of EF Assessment: Unknown | Ethnicity | Height cm Weight kg |
| < 1 Month 1-3 Months >3-6 Months | | |
| OTHER FACTORS affecting priorit | PATIENT OPTIONS for Timely A | |
| Other clinical factors Non-clin | check box if you (physician) have discussed | d with this patient (and/or significant others) timely access to care options for this procedure. |