

CATH REFERRAL

DATE OF REQUEST (DOR): - -

Date Format YYYY-MM-DD

IMPORTANT: Notify CATH centre of any change in the patient's condition

PHYSICIAN DETAILS

NAME of Referring Physician

Type

- ☐
- Specialist
- ☐
- Family/GP
-
- ☐
- Referring MD is out-of-province

NAME of GP/Family Physician (if different from Referring)

Date of Request for Specialist Consult

 - -

Date Format YYYY-MM-DD

NAME of Requested Procedural Physician(s)

☐ or 1st Available

PRIMARY REASON FOR REFERRAL

- ☐
- Coronary Disease (CAD)
-
- ☐
- Stable CAD
- ☐
- Unstable Angina
-
- ☐
- STEMI
- ☐
- NSTEMI
-
- ☐
- Rule Out CAD
-
- ☐
- Other:
-
- ☐
- Research
- ☐
- Biopsy

SECONDARY REASON

- ☐
- Aortic Stenosis
-
- Echo valve area
-
- cm
- ²
-
- Echo gradient
-
- mmHg
-
- ☐
- Other Valvular
-
- ☐
- Heart Failure
-
- ☐
- Congenital
-
- ☐
- Arrhythmia Specify
-
- ☐
- Cardiomyopathy
-
- ☐
- Other Specify

REQUEST TYPE

- ☐
- Referral for CATH and consultation regarding subsequent management
-
- ☐
- No consult required - CATH only

URGENCY (estimate from Referring Physician) (select 1 only)

- ☐
- Emergent
- ☐
- Urgent (while still in hospital)
- ☐
- Urgent (within 2 wks)
- ☐
- Elective

PATIENT WAIT LOCATION

☐ Hospital: Specify☐ Home ☐ ICU/CCU ☐ Ward: Specify ☐ Other: SpecifyTranslator Required? ☐ No ☐ Yes: Language

RECENT or PREVIOUS MI

- History of MI**
- ☐
- No
- ☐
- Yes
-
- ☐
- 1-3 Months
- ☐
- >3-6 Months
- ☐
- >6-12 Months
- ☐
- >1 Year
- ☐
- Unknown
-
- Recent MI**
- (Within 30 Days)
- ☐
- No
- ☐
- Yes Date:
-
-
-
-
-
-
- ☐
- Date unknown

CCS/ACS ANGINA CLASS

Stable CAD

- ☐
- 0
- ☐
- I
- ☐
- II
- ☐
- III
- ☐
- IV →

Date: - -

Acute Coronary Syndrome (ACS)

- ☐
- Low Risk (IV-A)
- ☐
- Intermediate Risk (IV-B)
-
- ☐
- High Risk (IV-C)
- ☐
- Emergent (IV-D)
-
- ☐
- Hemodynamically unstable (i.e., requires inotropic or vasopressor or balloon pump)

HEART FAILURE CLASS (NYHA)

- ☐
- I
- ☐
- II
- ☐
- III
- ☐
- IV
- ☐
- Not applicable

REST ECG

☐ Done ☐ Not done

Ischemic changes at rest?

- ☐
- Yes
- ☐
- No
- ☐
- Uninterpretable

Type: ☐ Not applicable ☐ Persistent
☐ Transient w/ pain ☐ Transient w/o pain

EXERCISE ECG

☐ Done ☐ Not doneRisk: ☐ Not applicable
☐ Low ☐ High ☐ Uninterpretable

FUNCTIONAL IMAGING

☐ Done ☐ Not doneRisk: ☐ Low ☐ High ☐ Not applicable

LV FUNCTION

☐ Done ☐ Not done

Method:

☐ Other ☐ ECHO ☐ MUGA ☐ Ventriculogram

Findings:

- ☐
- I (>=50%)
- ☐
- II (35-49%)
- ☐
- III (20-34%)
- ☐
- IV (<20%)
-
- ☐
- Not applicable

LV Function Percentage: %Date of EF Assessment: ☐ Unknown☐ < 1 Month ☐ 1-3 Months ☐ >3-6 Months ☐ 6+ Months

OTHER FACTORS affecting prioritization

- ☐
- Other clinical factors
- ☐
- Non-clinical factors

Patient Information (Addressograph)

Pt Name: DOB: / / MRN/Hospital Chart # :

Address:

City/Town: Province: Postal Code: E-mail Contact: Home Phone #: - - Other Contact #: - - Health Card Number:

For Coordinator Use ONLY

RMWT

URS

WAIT

Referral Date: - - Acceptance Date: - - Inpt Admit Date: - - Booking Date: - - Transfer Date: - - Discharge Date: - -

Scheduling Details

Date Format YYYY-MM-DD

☐ DART - - to - - ☐ CANCELLATION - - ☐ MEDICAL DELAY - -

FAX CATH Report to:

Person/Organization:

Fax Number: - - E-mail:

SPECIAL INSTRUCTIONS and/or BRIEF HISTORY

☐ Previous CATH done outside of Ontario