CorHealth Ontario

Thunder Bay Regional Health Sciences Centre

Please fax the referral to 1-807-684-5902

Please include a complete patient history with this form

CATH REFERRAL

DATE OF REQUEST (DOR): ____ - ____ - ____
Date Format YYYY-MM-DD

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

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:

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

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 – –

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

FAX CATH Report to:

Person/Organization:

Fax Number: ___ - ___ - _____ E-mail:

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

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

SPECIAL INSTRUCTIONS and/or BRIEF HISTORY

☐ Previous CATH done outside of Ontario

PATIENT WAIT LOCATION

☐ Hospital: _____ Specify

☐ Home ☐ ICU/CCU ☐ Ward: _____ Specify ☐ Other: _____ Specify

Translator 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 done

Risk: ☐ Not applicable
☐ Low ☐ High ☐ Uninterpretable

FUNCTIONAL IMAGING

☐ Done ☐ Not done

Risk: ☐ 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

COMORBIDITY ASSESSMENT

Creatinine_____ µmol/L	☐ Known	☐ Pending	☐ Not done	
Dialysis	☐ No	☐ Yes		
Diabetes	☐ No	☐ Yes →	☐ Diet ☐ Insulin ☐ Oral Hypoglycemics ☐ No Treatment	
History of Smoking	☐ Never	☐ Current	☐ Former	☐ Unknown
Hypertension	☐ No	☐ Yes		
Hyperlipidemia	☐ No	☐ Yes		
Cerebral Vascular Disease (CVD)	☐ No	☐ Yes	☐ Unknown	
Peripheral Vascular Disease (PVD)	☐ No	☐ Yes		
COPD	☐ No	☐ Yes		
Previous (CABG) Bypass Surgery	☐ No	☐ Yes		
LIMA	☐ No	☐ Yes		
Previous PCI	☐ No	☐ Yes		
Anticoagulant	☐ No	☐ Yes		
→	☐ Coumadin	☐ Heparin	☐ LMWH	☐ Dabigatran ☐ If Other _____
On IIb/IIIa Inhibitors	☐ No	☐ Yes		
Dye Allergy	☐ No	☐ Yes	☐ Unknown	
Possible Intracardiac Thrombus	☐ No	☐ Yes	☐ Unknown	
Infective Endocarditis	☐ No	☐ Yes →	**Active Endocarditis**	☐ No ☐ Yes
Congenital Heart Disease	☐ No	☐ Yes		
History of CHF	☐ No	☐ Yes		
Ethnicity	☐ White	☐ Aboriginal	☐ South Asian	☐ Asian ☐ Black ☐ Other ☐ Unknown

*** **Provide separate documentation of previous number and location of grafts** ***

Prev CABG Date ____ – ____ – ____

Prev PCI Date ____ – ____ – ____

Height _____ cm **Weight** _____ kg

PATIENT OPTIONS for Timely Access to Care

☐ Check box if you (physician) have discussed with this patient (and/or significant others) timely access to care options for this procedure.

MD SIGNATURE **Date (YYYY-MM-DD):**