

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), NAME of GP/Family Physician, Date of Request for Specialist Consult, NAME of Requested Procedural Physician(s), Date Format YYYY-MM-DD

PRIMARY REASON FOR REFERRAL

SECONDARY REASON

Coronary Disease (CAD), Aortic Stenosis, Heart Failure, STEMI, NSTEMI, Rule Out CAD, Other Valvular, Arrhythmia, Congenital, Cardiomyopathy, Other

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, Home, ICU/CCU, Ward, Other, Translator Required? No/Yes

RECENT or PREVIOUS MI

History of MI (No/Yes), Recent MI (Within 30 Days) (No/Yes), Date

CCS/ACS ANGINA CLASS

Stable CAD (0-IV), Acute Coronary Syndrome (ACS) (Low/Intermediate/High Risk, Emergent)

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)

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-IV), LV Function Percentage, Date of EF Assessment

COMORBIDITY ASSESSMENT

Creatinine, Dialysis, Diabetes, History of Smoking, Hypertension, Hyperlipidemia, Cerebral Vascular Disease (CVD), Peripheral Vascular Disease (PVD), COPD, Previous (CABG) Bypass Surgery, LIMA, Previous PCI, Anticoagulant, On IIb/IIIa Inhibitors, Dye Allergy, Possible Intracardiac Thrombus, Infective Endocarditis, Congenital Heart Disease, History of CHF, Ethnicity, Height, Weight

OTHER FACTORS affecting prioritization

Other clinical factors, Non-clinical factors

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):

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

Referral Date, Acceptance Date, Inpt Admit Date, Booking Date, Transfer Date, Discharge Date

Scheduling Details

DART, 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