



Coronary Angiogram Referral Form



Instructions: Send to Regional Cardiac Centre directly. Do NOT send to CorHealth Ontario. Select only one option, unless noted otherwise.

Patient Information

First Name:		Middle Name:		Last Name:	
Heath Card Number:		Auth. Issuing:	DOB: YYYY-MM-DD	MRN:	
Street Address:			Suite:	City:	Prov./State:
Postal/Zip Code:	Country: If outside Canada	Primary Phone:		Alternate Phone:	

Language of Preference:

Referral Information

Referring Physician: Name and/or CPSO Number

Wait Location: Indicate Hospital name OR select a location
 Home Rehabilitation Facility Medical Facility Outside of Province Medical Facility Outside of Country

Reasons for Referral: Primary reason for the patient's referral is required. Indicate the appropriate reason by adding a P beside your selection to indicate Primary Reason for Referral, and S, if applicable, to indicate one Secondary Reason for Referral.

Coronary Disease: <input type="checkbox"/> Stable Angina (or Equivalent) <input type="checkbox"/> Unstable Angina (or Equivalent) <input type="checkbox"/> Non-ST-Segment Elevation Myocardial Infarction (NSTEMI) <input type="checkbox"/> ST-Segment Elevation Myocardial Infarction (STEMI)	Arrhythmia: <input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Atypical Atrial Flutter <input type="checkbox"/> Atrioventricular Nodal Re-entrant Tachycardia (AVNRT) <input type="checkbox"/> Atrial Tachycardia <input type="checkbox"/> Paroxysmal Atrial Fibrillation <input type="checkbox"/> Persistent Atrial Fibrillation <input type="checkbox"/> Ventricular Fibrillation <input type="checkbox"/> Ventricular Tachycardia <input type="checkbox"/> Wolff-Parkinson-White Syndrome	<input type="checkbox"/> Cardiomyopathy
		<input type="checkbox"/> Congenital/Structural
Valve Disease: <input type="checkbox"/> Aortic Regurgitation <input type="checkbox"/> Aortic Stenosis <input type="checkbox"/> Other Valvular		<input type="checkbox"/> Heart Failure
		Heart Transplant: <input type="checkbox"/> Donor <input type="checkbox"/> Recipient
		Other: <input type="checkbox"/> Heart Disease of Other Etiology <input type="checkbox"/> Protocol (Research/Employment) <input type="checkbox"/> Syncope

Additional Notes:

Diagnostic Information

History of Myocardial Infarction: <input type="checkbox"/> Recent (≤30 days) <input type="checkbox"/> History (>30 days) <input type="checkbox"/> No	History of Congestive Heart Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No	History of CABG Surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Serum Creatinine: _____ μmol/L	Height: _____ cm	Weight: _____ kg	
Canadian Cardiovascular Society Classification: <input type="checkbox"/> 0 <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV Acute Coronary Syndrome Classification: <input type="checkbox"/> Low Risk <input type="checkbox"/> Intermediate Risk <input type="checkbox"/> High Risk <input type="checkbox"/> Emergent	Exercise ECG Risk: <input type="checkbox"/> Low Risk <input type="checkbox"/> High Risk <input type="checkbox"/> Uninterpretable <input type="checkbox"/> Not Done	Rest ECG Ischemic Changes: <input type="checkbox"/> Persistent (Fixed) <input type="checkbox"/> Transient without Pain <input type="checkbox"/> Transient with Pain <input type="checkbox"/> Uninterpretable <input type="checkbox"/> No	Functional Imaging Risk: <input type="checkbox"/> Low Risk <input type="checkbox"/> High Risk <input type="checkbox"/> Uninterpretable <input type="checkbox"/> Not Done
<input type="checkbox"/> Cardiogenic Shock			

Referring Physician Signature: _____ **Date:** YYYY-MM-DD