

Cardiology Referral Form

For Cath Lab Procedures or Inpatient Transfer

Request for:

- ☐ Cardiac Catheterization, PPCI, or Other Intervention (includes requests for 24h transfer)
☐ Transfer for Ongoing Care

Name: _____
 Address: _____
 Phone: (h) _____ (w) _____
 Health Card #: _____
 D.O.B.: _____ Gender: _____
 Family Dr.: _____
 Ref. Specialist: _____
 Referral Date (yyyy/mm/dd): _____

Patient Wait Location and Urgency
 Outpatient ☐ Urgent ☐ Semi-Urgent ☐ Scheduled
 Inpatient ☐ Referring Hospital & Unit: _____

Reason for Referral
☐ Coronary Artery Disease
 ☐ Rule out CAD: ☐ Stable Angina
 ☐ NSTEMI ☐ Unstable Angina ☐ NSTEMI
 ☐ Low risk* ☐ Int risk* ☐ High risk*
 GRACE Risk Score* _____ TIMI Risk Score* _____
 ☐ STEMI ☐ Primary PCI ☐ Pharmacoinvasive
 ☐ Rescue PCI ☐ Other _____

☐ Valvular Heart Disease
 ☐ Aortic Stenosis ☐ Other Valvular: _____
 Valve Area _____ MG _____ PG _____

☐ Congestive Heart Failure / Cardiomyopathy
☐ Arrhythmia ☐ Congenital ☐ Other: _____

Requested Procedure
☐ Coronaries ☐ Grafts ☐ Right Heart Cath
☐ Left Heart Cath ☐ with LV Gram ☐ without LV Gram
☐ PCI ☐ Vessel(s) if known anatomy: _____
☐ TAVI ☐ PFO/ASD Closure ☐ Biopsy
☐ Other: _____

ECG
 Ischemic Changes? ☐ Yes ☐ No ☐ Uninterpretable

Exercise ECG ☐ Done ☐ Not Done
 High Risk Features ☐ Yes ☐ No ☐ Nondiagnostic

Perfusion Imaging ☐ Done ☐ Not Done
 High Risk Features ☐ Yes ☐ No ☐ Nondiagnostic

Stress Echo ☐ Done ☐ Not Done
 High Risk Features ☐ Yes ☐ No ☐ Nondiagnostic

Coronary CTA ☐ Done ☐ Not Done
 High Risk Features ☐ Yes ☐ No ☐ Nondiagnostic

Assessment of LV Function ☐ Yes ☐ No
 Method: ☐ Echo ☐ Perfusion Imaging
☐ Wall Motion Study ☐ Other: _____
 EF %: _____

Brief Clinical History and Special Instructions

Comorbidity Assessment

- ☐ Previous Cath/PCI: _____ Date: _____
☐ Previous CABG: _____ Date: _____
☐ Previous Valve Surgery: _____ Date: _____
 ☐ Bioprosthetic ☐ Mechanical
☐ Diabetes ☐ Insulin
☐ Hypertension ☐ Dyslipidemia
☐ Smoking ☐ Yes ☐ No ☐ Quit (date): _____
☐ Family History Premature CAD
☐ Renal Insufficiency ☐ Dialysis
☐ Atrial Fibrillation
☐ Cerebrovascular Disease ☐ TIA ☐ Stroke
☐ Peripheral Vascular Disease
☐ CHF ☐ COPD ☐ Asthma
☐ Infective Endocarditis
☐ DVT/PE ☐ GI Bleed ☐ Other: _____

Allergies

- ☐ None ☐ Contrast Dye
☐ Latex ☐ ASA
☐ Other: _____

Blood Work

Date: _____
 Hb: _____ Cr: _____
 eGFR: _____ INR: _____

Other Details

Height: _____ cm
 Weight: _____ kg

Carrier Status

- MRSA ☐ Contact ☐ Carrier
 VRE ☐ Contact ☐ Carrier

Medications

- ☐ Warfarin ☐ Apixiban ☐ Dabigatran ☐ Edoxaban ☐ Rivaroxaban
 Bridging Anticoagulation Required ☐ Yes ☐ No
☐ Enoxaparin ☐ Fondaparinux ☐ Metformin ☐ IV NTG ☐ IV Amiodarone
 Able to tolerate dual antiplatelet therapy ☐ Yes ☐ No

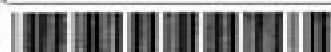
Frailty Score*

* Please see "Cardiology Referral Form - Definitions and Instructions for User"

Printed Name: _____ Signature: _____

Booking Use Only
 Pre-assessment Clinic Date: _____ / Time: _____ Procedure Date (yyyy/mm/dd): _____

Fax completed page 1 and other relevant information to 902-473-2271 (Bed Management Coordinator)
 For QEH and DGH inpatients only, please fax page 1 of completed form and other relevant information to 902-473-2571 (Cardiac Cath Lab)



Sample Cardiac Cath Lab 2013 Billing Sheet

L Cohen

A red circular graphic with a gradient, appearing as a semi-circle or a partial circle, located to the right of the L Cohen text.

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