

DATE OF REQUEST (DOF): - -
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 - -
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NAME of Requested Procedural Physician(s) or 1st Available

REASON(S) FOR REFERRAL

Enter **1** for primary reason and **2** for secondary reason (if any)

- Coronary Disease (CAD) Aortic Stenosis CHF/Cardiomyopathy
 Elective Stable CAD Echo valve area cm² Congenital
 Unstable Angina Echo gradient mmHg Arrhythmia
 NSTEMI Other Valvular Other:
 STEMI 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: Specify
Translator Required? No Yes: Language

RECENT or PREVIOUS MI

History of MI No Yes
Recent MI No Yes Date: - -
 Date unknown

CCS/ACS ANGINA CLASS

Stable CAD 0 I II III IV → 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

Method: Done Not done
 Other ECHO MUGA Ventriculogram
Findings: I (>50%) II (35-49%) III (20-34%) IV (<20%)
 Not applicable

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
Hypertension No Yes
Hyperlipidemia No Yes
Cerebral Vascular Disease (CVD) No Yes Unknown
Peripheral Vascular Disease (PVD) No Yes
Varicose Veins No Yes
COPD No Yes
Previous (CABG) Bypass Surgery No Yes *** Provide separate documentation of previous number and location of grafts ***
LIMA No Yes
Previous PCI No Yes
On Coumadin No Yes
On IIb/IIIa Inhibitors No Yes
Dye Allergy No Yes Unknown
Possible LV Thrombus No Yes Unknown
Infective Endocarditis No Yes
Active Endocarditis No Yes
History of CHF No Yes
Height cm Weight kg

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: ____ - ____
Letter Sent: ____ - ____	Brochure Sent: ____ - ____

Scheduling Details

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<input type="checkbox"/> DART	____ - ____ to ____ - ____
<input type="checkbox"/> CANCELLATION	____ - ____
<input type="checkbox"/> MEDICAL DELAY	____ - ____

FAX CATH Report to:

Person/Organization: _____
Fax Number: (____) ____ - ____ E-mail: _____

SPECIAL INSTRUCTIONS and/or BRIEF HISTORY

Previous CATH done outside of Ontario