ByWard FAMILY HEALTH TEAM

CARDIOLOGY REFERRAL FORM

General Cardiology Consultation

2–316 Rideau
Ottawa, Ontario K1N 5Y5
Tel: 613–564–3950
Fax: 613–564–6627
www.bywardfht.ca

1. PATIENT INFORMATION

Patient Name: ____________________

Date of Birth (yyyy/mm/dd): ____________________

Address: ____________________

City: ____________________ **Postal Code:** __________

Email Address: ____________________

Phone (Home): ____________________

Phone (Cell): ____________________

Health Insurance: ____________________

Primary Care Provider: ____________________

2. REFERRAL DETAILS

Urgency: ☐ Elective ☐ Routine (1–3 months) ☐ Urgent (1–2 weeks)

Reason for referral / Chief Complaint:

☐ Chest pain or Coronary Artery Disease (CAD) ☐ Murmur or valvular heart disease

☐ Heart Failure ☐ Palpitations, syncope, arrhythmia ☐ Second opinion

☐ Assessment prior to non-cardiac surgery: Surgery: ____________________

Planned OR date: ____________________

☐ Other: ____________________

3. CLINICAL SUMMARY / RELEVANT CLINICAL INFORMATION

Please include pertinent history, symptoms, duration, relevant investigations, and treatments tried.

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4. CARDIAC HISTORY & RISK FACTORS

Cardiac History *(please check all that apply)*

☐ Prior MI

☐ Prior Percutaneous Coronary Intervention (PCI)

☐ Prior cardiac surgery

☐ Atrial fibrillation

☐ Prior pacemaker or Implantable Cardioverter Defibrillator (ICD)

☐ Other: ____________________

Risk Factors *(please check all that apply)*

☐ Hypertension ☐ Obesity

☐ Diabetes ☐ Smoking

☐ Hyperlipidemia ☐ Family History CAD

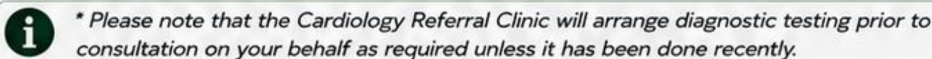
Height: __________ cm **Weight:** __________ kg

☐ Other: ____________________

5. PLEASE INCLUDE THE MOST RECENT INFORMATION WITH YOUR REFERRAL IF AVAILABLE

☐ Blood work ☐ ECG ☐ Cardiac diagnostic testing

☐ Pertinent medical records such as Emergency Department (ED) visits, previous cardiology consultations, prior admissions ☐ Latest medication list



** Please note that the Cardiology Referral Clinic will arrange diagnostic testing prior to consultation on your behalf as required unless it has been done recently.*

6. REFERRING PROVIDER INFORMATION

Referring Provider (printed name): ____________________ | **Signature:** ____________________ | **Date** (yyyy/mm/dd): __________

OHIP Billing Number: ____________________ | **Phone Number:** ____________________ | **Fax Number:** ____________________