CARDIAC CARE NETWORK

CATH REFERRAL

DATE OF REQUEST (DOR): ____ – ____ – ____

Date Format YYYY-MM-DD

Please fax the referral to 519-749-6606

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 ____ – ____ – ____

Date Format YYYY-MM-DD

NAME of Requested Procedural Physician(s)

☐ or 1st Available

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

RMWT URS WAIT

Referral Date: – –	Acceptance Date: – –
Inpt Admit Date: – –	Booking Date: – –
Transfer Date: – –	Discharge Date: – –

Scheduling Details **Date Format YYYY-MM-DD**

☐ DART – – to – –
☐ CANCELLATION – –
☐ MEDICAL DELAY – –

PRIMARY REASON FOR REFERRAL

☐ Coronary Disease (CAD)
☐ Stable CAD ☐ Unstable Angina
☐ STEMI ☐ NSTEMI
☐ Rule Out CAD
☐ Other:
☐ Research ☐ Biopsy

SECONDARY REASON

☐ Aortic Stenosis
Echo valve area ____ cm^2
Echo gradient ____ mmHg
☐ Other Valvular
☐ Heart Failure
☐ Congenital
☐ Arrhythmia Specify
☐ Cardiomyopathy
☐ Other Specify

REQUEST TYPE

☐ Referral for CATH and consultation regarding subsequent management
☐ No consult required – CATH only

FAX CATH Report to:

Person/Organization:

Fax Number: ( ) - E-mail:

URGENCY (estimate from Referring Physician) (select 1 only)

☐ Emergent ☐ Urgent (while still in hospital) ☐ Urgent (within 2 wks) ☐ Elective

SPECIAL INSTRUCTIONS and/or BRIEF HISTORY

☐ Previous CATH done outside of Ontario

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
☐ 1-3 Months ☐ >3-6 Months ☐ >6-12 Months ☐ >1 Year ☐ Unknown

Recent MI (Within 30 Days) ☐ No ☐ Yes Date: ____ – ____ – ____
☐ Date unknown

CCS/ACS ANGINA CLASS

Stable CAD
☐ 0 ☐ I ☐ II ☐ III ☐ IV
Date: ____ – ____ – ____

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

☐ Done ☐ Not done

Method:
☐ Other ☐ ECHO ☐ MUGA ☐ Ventriculogram

Findings:
☐ I(>=50%) ☐ II (35–49%) ☐ III(20–34%) ☐ IV (<20%)
☐ Not applicable

LV Function Percentage: ____ %

Date of EF Assessment: ☐ Unknown
☐ < 1 Month ☐ 1-3 Months ☐ >3-6 Months ☐ 6+ Months

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 ☐ Unknown
Hypertension ☐ No ☐ Yes
Hyperlipidemia ☐ No ☐ Yes
Cerebral Vascular Disease (CVD) ☐ No ☐ Yes ☐ Unknown
Peripheral Vascular Disease (PVD) ☐ No ☐ Yes
COPD ☐ No ☐ Yes
Previous (CABG) Bypass Surgery ☐ No ☐ Yes
*** Provide separate documentation of previous number and location of grafts ***
LIMA ☐ No ☐ Yes Prev CABG Date ____ – ____ – ____
Previous PCI ☐ No ☐ Yes Prev PCI Date ____ – ____ – ____
Anticoagulant ☐ No ☐ Yes
→ ☐ Coumadin ☐ Heparin ☐ LMWH ☐ Dabigatran ☐ If Other ____
On IIb/IIIa Inhibitors ☐ No ☐ Yes
Dye Allergy ☐ No ☐ Yes ☐ Unknown
Possible Intracardiac Thrombus ☐ No ☐ Yes ☐ Unknown
Infective Endocarditis ☐ No ☐ Yes → **Active Endocarditis** ☐ No ☐ Yes
Congenital Heart Disease ☐ No ☐ Yes
History of CHF ☐ No ☐ Yes
Ethnicity ☐ White ☐ Aboriginal ☐ South Asian ☐ Asian ☐ Black ☐ Other ☐ Unknown

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):**