CARDIAC CARE NETWORK

CATH REFERRAL

DATE OF REQUEST (DOR): ____ – ____ – ____
Date Format YYYY-MM-DD

IMPORTANT: Notify CATH centre of any change in the patient's condition

THUNDER BAY Regional Health SCIENCES CENTRE

Please fax the referral to 1-807-684-5902

Patient Information (Addressograph)

Pt Name: _____

DOB: ____ / ____ / ____ MRN/Hospital Chart # :

Address:

City/Town: Province: ON Postal Code:

E-mail Contact:

Home Phone #: (___) ___ - ____ Other Contact #: (___) ___ - ____

Health Card Number:

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

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

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	– –		

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

PATIENT WAIT LOCATION

☐ Hospital: Specify

☐ Home ☐ ICU/CCU ☐ Ward: Specify ☐ Other: Specify

Translator Required? ☐ No ☐ Yes: Language

SPECIAL INSTRUCTIONS and/or BRIEF HISTORY

☐ Previous CATH done outside of Ontario

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

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)

Date: ____ – ____ – ____

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):**