



CATH REFERRAL

DATE OF REQUEST (DOR): - -
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
 - -
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

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 ____ cm²
 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 →

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

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
 LIMA No Yes
 Previous PCI No Yes

Anticoagulant 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

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

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): _____