Coronary Angiogram Referral Form

Instructions: Fax to **WRH Cardiac Cath Lab 519-973-5584**. Do NOT send to CorHealth Ontario. Select only one option, unless noted otherwise.

Patient Information

NAME of Referring Physician:

NAME of GP/Family Physician:

NAME of Requested Procedural Physician:

Pt Name:

DOB: YYYY-MM-DD

Address:

Primary Number: **Alternate Phone:**

Heath Card Number: **RMWT:**

Race: Race is self-identified by the patient. Patient may identify as one or more option.

☐ Black ☐ East/Southeast Asian ☐ Indigenous (First Nations, Métis, Inuk/Inuit) ☐ Latino ☐ Middle Eastern ☐ South Asian ☐ White ☐ Other

The following options cannot be indicated with any other option: ☐ Unknown ☐ Prefer Not to Answer ☐ Not Collected

Referral Information

Wait Location: Indicate Hospital name OR select a location

☐ Home **Elective** ☐ **Within 2 weeks** ☐ ☐Hospital _____ ☐ Unit_____

Reasons for Referral: Primary reason for the patient's referral is required. Indicate the appropriate reason by adding a P beside your selection to indicate Primary Reason for Referral, and S, if applicable, to indicate one Secondary Reason for Referral.

Coronary Disease:

__ Stable Angina (or Equivalent)

__ Unstable Angina (or Equivalent)

__ Non-ST-Segment Elevation Myocardial Infarction (NSTEMI)

__ ST-Segment Elevation Myocardial Infarction (STEMI)

Valve Disease:

__ Aortic Regurgitation

__ Aortic Stenosis

__ Other Valvular

Arrhythmia:

__ Atrial Flutter

__ Atypical Atrial Flutter

__ Atrioventricular Nodal Re-entrant Tachycardia (AVNRT)

__ Atrial Tachycardia

__ Paroxysmal Atrial Fibrillation

__ Persistent Atrial Fibrillation

__ Ventricular Fibrillation

__ Ventricular Tachycardia

__ Wolff-Parkinson-White Syndrome

__ **Cardiomyopathy**

__ **Congenital/Structural**

__ **Heart Failure**

Heart Transplant:

__ Donor

__ Recipient

Other:

__ Heart Disease of Other Etiology

__ Protocol (Research/Employment)

__ Syncope

Additional Notes:

Diagnostic Information

History of Myocardial Infarction:
☐ Recent (≤30 days) ☐ History (>30 days) ☐ No

History of Congestive Heart Failure:
☐ Yes ☐ No

History of CABG Surgery: ☐ Yes ☐ No

Previous PCI ☐ Yes ☐ No

Serum Creatinine: _____ µmol/L

Dialysis ☐ Yes ☐ No

Height: _____ cm

Weight: _ _____ kg

Anticoagulation ☐ Yes ☐ No

Dye Allergy ☐ Yes ☐ No

Canadian Cardiovascular Society Classification:
☐ 0 ☐ I ☐ II ☐ III ☐ IV

Acute Coronary Syndrome Classification:
☐ Low Risk ☐ Intermediate Risk
☐ High Risk ☐ Emergent

☐ Cardiogenic Shock

Exercise ECG Risk:
☐ Low Risk
☐ High Risk
☐ Uninterpretable
☐ Not Done

Rest ECG Ischemic Changes:
☐ Persistent (Fixed)
☐ Transient without Pain
☐ Transient with Pain
☐ Uninterpretable
☐ No

Functional Imaging Risk:
☐ Low Risk
☐ High Risk
☐ Uninterpretable
☐ Not Done

Referring Physician Signature:

Date: YYYY-MM-DD