CARDIAC CARE NETWORK

CATH REFERRAL

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

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

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:

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

For Coordinator Use ONLY

RMWT URS WAIT

Referral Date: – –	Acceptance Date: – –
Inpt Admit Date: – –	Booking Date: – –
Transfer Date: – –	Discharge Date: – –
Letter Sent: – –	Brochure Sent: – –

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

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

REASON(S) FOR REFERRAL

Enter 1 for primary reason and 2 for secondary reason (if any)

☐ Coronary Disease (CAD)
- ☐ Elective Stable CAD
- ☐ Unstable Angina
- ☐ NSTEMI
- ☐ STEMI

☐ Aortic Stenosis
Echo valve area ____ cm^2
Echo gradient ____ mmHg

☐ Other Valvular

☐ CHF/Cardiomyopathy
☐ Congenital
☐ Arrhythmia
☐ 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

Translater Required? ☐ No ☐ Yes: ____ Language

RECENT or PREVIOUS MI

History of MI ☐ No ☐ Yes
Recent MI ☐ 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

OTHER FACTORS affecting prioritization

☐ Other clinical factors ☐ Non-clinical factors

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	
Hypertension	☐ No	☐ Yes		
Hyperlipidemia	☐ No	☐ Yes		
Cerebral Vascular Disease (CVD)	☐ No	☐ Yes	☐ Unknown	
Peripheral Vascular Disease (PVD)	☐ No	☐ Yes		
Varicose Veins	☐ No	☐ Yes		
COPD	☐ No	☐ Yes		
Previous (CABG) Bypass Surgery	☐ No	☐ Yes	*** Provide separate documentation of previous number and location of grafts ***	
LIMA	☐ No	☐ Yes		
Previous PCI	☐ No	☐ Yes		
On Coumadin	☐ No	☐ Yes		
On IIb/IIIa Inhibitors	☐ No	☐ Yes		
Dye Allergy	☐ No	☐ Yes	☐ Unknown	
Possible LV Thrombus	☐ No	☐ Yes	☐ Unknown	
Infective Endocarditis	☐ No	☐ Yes		
Active Endocarditis	☐ No	☐ Yes		
History of CHF	☐ No	☐ Yes	**Height** ____ cm	**Weight** ____ kg

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):**