St. Mary's REGIONAL CARDIAC CARE CENTRE

Patient Name: _____
Address: _____
_____
Phone Number: _____
Date of Birth: _____
Health Card # _____
Age: _____ Gender: ❑ M ❑ F

Request for Cardiac Surgery Consultation

Date of Referral: _____ Referring Physician: _____

Phone #: _____ Fax #: _____

Family Doctor/NP: _____ Cardiologist/Internist: _____

Patient Location: ❑ Home
❑ Inpatient at: _____

Consult requested for:
❑ CABG
❑ Valve (*For Valve referrals please enclose most recent Echo report)*
❑ Aortic Pathology
❑ Congenital/Structural (*Please note, SMGH does not have a pediatric program)*
❑ Other _____

Coronary Angiogram:
❑ Completed (*Please enclose angiogram diagram if not completed at SMGH)*

On _____ at _____
(Date) (Hospital)

❑ Not completed

❑ Pending _____ at _____
(Date) (Hospital)

Please **fax** this referral form along with the following information to (519) 749-6414:

❑ Recent blood work
❑ Medication list
❑ History and physical consult
❑ Any other relevant testing (i.e. Carotid Doppler's, CT Chest, Echocardiogram, PFT's)

Comments: _____

_____

Thank you for the referral.

If you have questions or concerns regarding this referral please contact:

Corrie Brubacher, RN
Regional Cardiac Care Coordinator
Cardiac Surgery and Pacemaker Insertions
(519) 749-6937 x 1936
Fax: (519) 749-6414
Email: cbrubacher@smgh.ca