Ontario Health
CorHealth Ontario

Coronary Angiogram Referral Form

St. Mary's Regional Cardiac Care Centre
Fax 1 519 749 6606

Instructions: Send to Regional Cardiac Centre directly. Do NOT send to CorHealth Ontario. Select only one option, unless noted otherwise.

Patient Information

First Name:	**Middle Name:**		**Last Name:**
Heath Card Number: Auth. Issuing:		**DOB:** YYYY-MM-DD	**MRN:**
Street Address:		**Suite:**	**City:** / **Prov./State:**
Postal/Zip Code:	**Country:** If outside Canada	**Primary Phone:**	**Alternate Phone:**
E Mail Address:		**Language of Preference:**	

Referral Information

Referring Physician: Name and/or CPSO Number

- ☐ **Left Heart Catheterization**
- ☐ **Left and Right Heart Study**
- ☐ **Right Heart Study**
- ☐ **Biopsy**

Wait Location: Indicate Hospital name OR select a location
☐ Home ☐ Hospital Inpt Location: Phone Ext:

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 Stenosis
- __ Aortic Regurgitation
- __ 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:

History of PVD: ☐ Yes ☐ No

History of Cerebral Vascular Disease (CVD): ☐ Yes ☐ No

Anticoagulant:
☐ Coumadin ☐ Apixaban
☐ Heparin ☐ Edoxaban
☐ LMWH ☐ Dabigatran
☐ Rivaroxaban

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
Where: When:

Serum Creatinine:
_____ µmol/L

Height: _____ cm
Weight: _____ kg

History of previous angioplasty: ☐ Yes ☐ No
Where: When:

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