



UNIVERSITY OF OTTAWA  
**HEART INSTITUTE**  
 INSTITUT DE CARDIOLOGIE  
 DE L'UNIVERSITÉ D'OTTAWA

*Hospital stamp here*

## Referral to Ottawa Pulmonary Hypertension Clinic

Date of request: \_\_\_\_\_ Referring MD: \_\_\_\_\_

Billing #: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB (yy/mm/dd): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Health Card #: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ MRN: \_\_\_\_\_

Brief history and reason for referral: \_\_\_\_\_

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**Please include the following information with your faxed referral, if available:**

- Patient's relevant past medical history
- Echocardiogram done in last 6 months
- Pulmonary function tests performed in last 6 months
- List of current medications
- Recent bloodwork
- Any other relevant test results (i.e., chest x-ray, CT scan, VQ scan, if done)

**Please fax referrals to: 613-696-7216**

*Telephone: 613-696-7000 ext. 15396*