**CONSULT REQUEST**
Cardiology Referral Clinic
cardiologyreferralclinic@ottawaheart.ca

TEL: 613-696-7000 x 15276  [ ] Physician office referral  [ ] Emergency Department (ED) referral
FAX: 613-696-7155

<table>
<thead>
<tr>
<th>Family physician</th>
<th>Ontario Health or from:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Other province [ ] Other country OR [ ] Not available</td>
</tr>
</tbody>
</table>

Refer to: [ ] First available Cardiologist [ ] Specific Cardiologist: ___________________________________________

[ ] Specific service (e.g. heart failure, arrhythmia, etc):

Urgency: [ ] Routine (within 4 - 6 weeks) [ ] Urgent (within 1 - 2 weeks) [ ] Emergent – Call Cardiology or send to ED

Reason for referral/Chief Complaint:

[ ] Chest pain or Coronary Artery Disease (CAD) [ ] Murmur or valvular heart disease [ ] Heart Failure

[ ] Palpitations, syncope, arrhythmia [ ] Congenital [ ] Second opinion

[ ] Assessment prior to non-cardiac surgery: Surgery: ___________________________ Planned OR date: _________________

[ ] Other: ___________________________________________________________________________________________________

Other Relevant clinical information: _______________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Has the patient seen a Cardiologist at the Heart Institute within the last two years? [ ] Yes [ ] No

If yes, please specify: _______________________________________________________________________________________

Cardiac History:

[ ] Prior MI [ ] Prior Percutaneous Coronary Intervention (PCI) [ ] Prior cardiac surgery [ ] Atrial fibrillation

[ ] Prior pacemaker or Implantable Cardioverter Defibrillator (ICD) [ ] Other: ______________________________________

Risk Factors:

[ ] Hypertension [ ] Smoking [ ] Diabetes [ ] Hyperlipidemia [ ] Family History CAD

Height: ________ cm  Weight: ________ kg  [ ] Other: __________________________________________________________________________

Please include the most recent information with your referral if available:

- Blood work
- ECG
- Cardiac diagnostic testing
- Pertinent medical records such as Emergency Department (ED) visits, previous cardiology consultations, prior admissions
- Latest medication list

* Please note that the Cardiology Referral Clinic will arrange diagnostic testing prior to consultation on your behalf as required unless it has been done recently. *