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

CONSULT REQUEST
Cardiology Referral Clinic

cardiologyreferralclinic@ottawaheart.ca

TEL: 613-696-7000 x 15276
FAX: 613-696-7155

❑ **Physician office referral**
❑ **Emergency Department (ED) referral**

Family physician	Ontario Health or from: ❑ Other province ❑ Other country OR ❑ Not available

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. ***

Referring Physician printed name	Signature	Date (yyyy/mm/dd)	Time	OHIP billing number