

UOHI Coronary Function and Imaging Clinic – Referral Form

Fax referrals to: 613-696-7283

Date of request:	Referring MD:	Billing #:
Phone:	Fax:	
Family Physician:		
Phone:	Fax:	

Patient Information:

Patient Name:	DOB (yy/mm/dd):	
Health Card #:	MRN:	
Address:		
City:	Postal Code:	Telephone:

Reason for Referral / Clinical Question:

Suspected microvascular dysfunction (CMVD)
Spontaneous Coronary Artery Dissection (SCAD)

Myocardial Infarction with no obstructive CAD (MINOCA)

Referral criteria (must meet all three)

Followed by a Cardiologist/Internist?
Testing for CAD done and suggests
no obstructive CAD (LHC, cardiac CT).

Patient with cardiac or probable cardiac chest pain or
ischemic symptoms.

Relevant Cardiac Investigations (last 12 months):

Stress Test Echocardiogram Holter Coronary Angiography CCTA Cardiac MRI

Required Attachments:

Please include the following information or your consultation will be rejected.

- Last cardiac consultation note with current medications
- Cardiac testing reports (echo, cath, SPECT, PET, EXT, Stress echo, cardiac MRI)
- Lab results

Referral Submission:

Fax referrals to: 613-696-7283 Telephone: 613-696-7000 ext 67280