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

Stamp

Referral to the Heart Institute Aortic Clinic

Date of request:		Referring MD:	
Family Physician:		Phone:	
Phone:		Fax:	
Fax:		Billing #:	
Patient Name:		DOB (yy/mm/dd):	
Address:		City:	
Postal Code:		Health Card #:	
Telephone:		MRN:	

Brief history and reason for referral:

Type of Aortic Pathology

☐ Aneurysm ☐ Dissection ☐ Penetrating Ulcer/Intramural hematoma

☐ Other

Location of Aortic Pathology

☐ Aortic Root ☐ Ascending Aorta ☐ Aortic Arch

☐ Descending Thoracic Aorta ☐ Abdominal Aorta

☐ Other

Investigations: (in the past 6 months)

☐ Echo ☐ CT Scan ☐ MRI

☐ Other

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

- Patient's relevant past medical history
- Imaging studies (include CD with images if done outside of The Ottawa Hospital)
- List of current medications
- Recent blood work
- Any other relevant test results

Please fax referrals to: 613-761-5107
Telephone: 613-798-5555 ext.16793