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: _____

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: 613-761-4327

Telephone: 613-761-5396

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