CorHealth Ontario

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Please fax the referral to 416-469-6443

CATH REFERRAL

DATE OF REQUEST (DOR): ☐☐☐☐ - ☐☐ - ☐☐
Date Format YYYY-MM-DD

IMPORTANT: Notify CATH centre of any change in the patient's condition

PHYSICIAN DETAILS

NAME of Referring Physician

Type
☐ Specialist ☐ Family/GP
☐ Referring MD is out-of-province

NAME of GP/Family Physician (if different from Referring)

Date of Request for Specialist Consult
☐☐☐☐ - ☐☐ - ☐☐
Date Format YYYY-MM-DD

NAME of Requested Procedural Physician(s)

☐ or 1st Available

PRIMARY REASON FOR REFERRAL / SECONDARY REASON

☐ Coronary Disease (CAD)
- ☐ Stable CAD ☐ Unstable Angina
- ☐ STEMI ☐ NSTEMI
- ☐ Rule Out CAD

☐ Other:
- ☐ Research ☐ Biopsy

☐ Aortic Stenosis
Echo valve area _____ cm^2
Echo gradient _____ mmHg

☐ Other Valvular

☐ Heart Failure
☐ Congenital
☐ Arrhythmia Specify
☐ Cardiomyopathy
☐ Other Specify

REQUEST TYPE

☐ Referral for CATH and consultation regarding subsequent management
☐ No consult required – CATH only

URGENCY (estimate from Referring Physician) (select 1 only)

☐ Emergent ☐ Urgent (while still in hospital) ☐ Urgent (within 2 wks) ☐ Elective

PATIENT WAIT LOCATION

☐ Hospital: Specify
☐ Home ☐ ICU/CCU ☐ Ward: Specify ☐ Other: Specify

Translator Required? ☐ No ☐ Yes: Language

RECENT or PREVIOUS MI

History of MI ☐ No ☐ Yes
☐ 1-3 Months ☐ >3-6 Months ☐ >6-12 Months ☐ >1 Year ☐ Unknown

Recent MI (Within 30 Days) ☐ No ☐ Yes Date: ☐☐☐☐ - ☐☐ - ☐☐
☐ Date unknown

HEART FAILURE CLASS (NYHA)

☐ I ☐ II ☐ III ☐ IV ☐ Not applicable

REST ECG

☐ Done ☐ Not done
Ischemic changes at rest?
☐ Yes ☐ No ☐ Uninterpretable
Type: ☐ Not applicable ☐ Persistent ☐ Transient w/ pain ☐ Transient w/o pain

EXERCISE ECG

☐ Done ☐ Not done
Risk: ☐ Not applicable ☐ Low ☐ High ☐ Uninterpretable

FUNCTIONAL IMAGING

☐ Done ☐ Not done
Risk: ☐ Low ☐ High ☐ Not applicable

LV FUNCTION

☐ Done ☐ Not done
Method:
☐ Other ☐ ECHO ☐ MUGA ☐ Ventriculogram
Findings:
☐ I(>=50%) ☐ II(35-49%) ☐ III(20-34%) ☐ IV(<20%)
☐ Not applicable
LV Function Percentage: _____ %
Date of EF Assessment: ☐ Unknown
☐ < 1 Month ☐ 1-3 Months ☐ >3-6 Months ☐ 6+ Months

OTHER FACTORS affecting prioritization

☐ Other clinical factors ☐ Non-clinical factors

Patient Information (Addressograph)

Pt Name: _____
DOB: ____/____/____ MRN/Hospital Chart # :
Address:
City/Town: Province: Postal Code:
E-mail Contact: _____
Home Phone #: ___-___-____ Other Contact #: ___-___-____
Health Card Number:

For Coordinator Use ONLY

RMWT | URS | WAIT

Referral Date:	-- --	Acceptance Date:	-- --
Inpt Admit Date:	-- --	Booking Date:	-- --
Transfer Date:	-- --	Discharge Date:	-- --

Scheduling Details **Date Format YYYY-MM-DD**

☐ DART -- -- to -- --
☐ CANCELLATION -- --
☐ MEDICAL DELAY -- --

FAX CATH Report to:

Person/Organization:
Fax Number: ___-___-____ E-mail:

SPECIAL INSTRUCTIONS and/or BRIEF HISTORY

☐ Previous CATH done outside of Ontario

CCS/ACS ANGINA CLASS

Stable CAD
☐ 0 ☐ I ☐ II ☐ III ☐ IV →
Date: ☐☐☐☐ - ☐☐ - ☐☐

Acute Coronary Syndrome (ACS)
☐ Low Risk (IV-A) ☐ Intermediate Risk (IV-B)
☐ High Risk (IV-C) ☐ Emergent (IV-D)
→ ☐ Hemodynamically unstable (i.e., requires inotropic or vasopressor or balloon pump)

COMORBIDITY ASSESSMENT

Creatinine _____ µmol/L	☐ Known	☐ Pending	☐ Not done
Dialysis	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes →	☐ Diet ☐ Insulin ☐ Oral Hypoglycemics ☐ No Treatment
History of Smoking	☐ Never	☐ Current	☐ Former ☐ Unknown
Hypertension	☐ No	☐ Yes	
Hyperlipidemia	☐ No	☐ Yes	
Cerebral Vascular Disease (CVD)	☐ No	☐ Yes	☐ Unknown
Peripheral Vascular Disease (PVD)	☐ No	☐ Yes	
COPD	☐ No	☐ Yes	
Previous (CABG) Bypass Surgery	☐ No	☐ Yes	
LIMA	☐ No	☐ Yes	
Previous PCI	☐ No	☐ Yes	
Anticoagulant	☐ No	☐ Yes	
→	☐ Coumadin	☐ Heparin	☐ LMWH ☐ Dabigatran ☐ If Other _____
On IIb/IIIa Inhibitors	☐ No	☐ Yes	
Dye Allergy	☐ No	☐ Yes	☐ Unknown
Possible Intracardiac Thrombus	☐ No	☐ Yes	☐ Unknown
Infective Endocarditis	☐ No	☐ Yes →	**Active Endocarditis** ☐ No ☐ Yes
Congenital Heart Disease	☐ No	☐ Yes	
History of CHF	☐ No	☐ Yes	
Ethnicity	☐ White	☐ Aboriginal	☐ South Asian ☐ Asian ☐ Black ☐ Other ☐ Unknown

Height _____ cm **Weight** _____ kg

*** Provide separate documentation of previous number and location of grafts ***
Prev CABG Date ☐☐☐☐ - ☐☐ - ☐☐
Prev PCI Date ☐☐☐☐ - ☐☐ - ☐☐

PATIENT OPTIONS for Timely Access to Care

☐ Check box if you (physician) have discussed with this patient (and/or significant others) timely access to care options for this procedure.

MD SIGNATURE **Date (YYYY-MM-DD):**