



WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

76 Grenville Street, 4th Floor
Toronto, Ontario M5S 1B2

Tel: 416-323-7723
Fax: 416-323-6304

CARDIOLOGY REFERRAL FORM

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ Date of Birth: ____/____/____
DD/MM/YYYY
Health Card: _____ Version Code: _____
Address: _____
Telephone: _____ Alternate: _____

Referral Date: ____/____/____ Priority Urgent (7-10 days) **OR** First available
DD/MM/YYYY **OR** Specific MD: _____

ADDITIONAL PATIENT INFORMATION

Other insurance coverage (IFH, UHIP, other): Self-pay
Language spoken: _____ Interpreter required: Yes No
Allergies: _____
Gender: _____

REFERRING PROVIDER INFORMATION

Name: _____ Billing number: _____
Address: _____
Telephone: _____ Signature: _____
Fax: _____

Primary Care Provider: Same
 Other (name/contact information): _____

PLEASE INCLUDE MOST RECENT ECG

REASON FOR REFERRAL

Conditions:
 Hypertension
 Coronary Artery disease
 Heart Failure (include most recent Echo)
For urgent assessment in the Heart Function Clinic patient must meet following criteria (For all other Heart Failure patients can refer to general cardiology):
 Diagnosis of Heart Failure
 A recent hospitalization or high risk (≥ 1 hospitalization/ED visit in the last year)
 NYHA II-IV
 Current health status and/or goals of care preclude cardiac transplantation or mechanical circulatory support
 Recent Cardiac Event/Hospitalization
 Abnormal Cardiac Testing (please attach results if not done at WCH)
 Other: _____

Symptoms
 Chest Pain
 Shortness of breath
 Palpitations
 Presyncope
 Syncope
 Other: _____

Relevant Clinical Information: _____

Fax Disclaimer: This fax transmission contains confidential information that is intended only for the Women's College Hospital Clinics. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of the contents of this fax is strictly prohibited. If you have received this fax transmission in error, please immediately notify the referring health practitioner at the telephone number provided above to arrange for the return or destruction of this document.

