WCHI
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

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

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

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ Date of Birth: ____/____/____
DD/MM/YYYY

Health Card: _____ Version Code: _____

Address: _____

Telephone: _____ Alternate: _____

CARDIOLOGY REFERRAL FORM

Referral Date: ____/____/____
DD/MM/YYYY

Priority ❑ Urgent (7-10 days) **OR** ❑ First available
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:

Fax: Signature: _____

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: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____