CARDIOVASCULAR AUTONOMIC DISORDERS REFERRAL

REFERRAL DATE: / / DD / MM / YYYY

ADDITIONAL PATIENT INFORMATION

Preferred name: ☐
Gender (if not same as above):
☐ He/Him ☐ She/Her ☐ They/Them ☐

Pronouns: ☐

Other insurance coverage (IFH, UHIP, etc.):
☐ Self-pay

Language spoken: ☐
Interpreter required: ☐ Yes ☐ No

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

☐ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: ______________________________  Phone:______________  Fax:______________

REASON FOR REFERRAL

For assessment/treatment/management of:
☐ Orthostatic lightheadedness (orthostatic intolerance)
☐ Neurogenic orthostatic hypotension and/or Supine hypertension in the setting of:
  ☐ Pure autonomic failure
  ☐ Multiple system atrophy
  ☐ Parkinson’s disease
  ☐ Baroreflex failure
  ☐ Autonomic neuropathy
☐ Postural Orthostatic Tachycardia Syndrome (POTS)
☐ Inappropriate Sinus Tachycardia (IST)

Conditions we do NOT assess/treat/manage:
☒ Non-postural dizziness
☒ Chronic Fatigue Syndrome (CFS)
☒ Myalgic Encephalomyelitis (ME)
☒ Unspecified fatigue
☒ Non-specific autoimmune conditions
☒ For diagnosis of mast cell diseases including Mast Cell Activation Syndrome (MCAS)
☒ Complex regional pain syndrome (CRPS)
☒ For diagnosis of Ehlers Danlos Syndrome (EDS)
☒ (Isolated) Gastro-intestinal conditions/symptoms
☒ (Isolated) Gastro-urinary/bladder symptoms
☒ Headache
☒ Idiopathic focal hyperhidrosis
☒ Lyme disease
☒ Post concussion syndrome
☒ Seizure or rule out seizure
☒ Psychiatric disorders
☒ Medication related tachycardia
☒ Tachycardia and/or hypotension in the setting of an eating disorder, eating disordered behaviour or malnutrition
☒ Autonomic dysreflexia, e.g. in the setting of spinal cord injury

Please also note we do NOT perform tilt table testing at this time.

When referring your patient, please consider that the below conditions preclude a diagnosis of POTS:
• Hypovolemia
• Anemia
• Endocrinopathy
• Medication effect (including stimulants, diuretics and norepinephrine reuptake inhibitors, alpha blockers, tricyclic antidepressants)
• Prolonged bedrest/deconditioning

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REQUIRED CLINICAL INFORMATION

These documents are required:

☐ Consultation reports

☐ Cardiac testing
   (if already done)

☐ Orthostatic vitals
   (please complete chart on right)

Orthostatic vitals: DATE _______________

DD / MM / YYYY

POSITION | BLOOD PRESSURE | HEART RATE
----------|----------------|-------------
Supine 5 min
Standing 1 min
Standing 3 min
Standing 5 min
Standing 8 min
Standing 10 min

Lack of key information or delay in providing relevant medical documentation may result in denial of the consultation.

ADDITIONAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):