Ontario Health
CorHealth Ontario

Coronary Angiogram Referral Form

WRHN @ Queen's Blvd.
Waterloo Regional Health Network

Fax 1 519 749 6606

Instructions: Send to Regional Cardiac Centre directly. Do NOT send to CorHealth Ontario. Select only one option, unless noted otherwise.

Patient Information

First Name:	Middle Name:	Last Name:

Heath Card Number:	Auth. Issuing:	DOB: YYYY-MM-DD	MRN:

Street Address:	Suite:	City:	Prov./State:

Postal/Zip Code:	Country: If outside Canada	Primary Phone:	Alternate Phone:

E Mail Address:	Language of Preference:

Referral Information

Referring Physician: Name and/or CPSO Number

Wait Location: Indicate Hospital name OR select a location

☐ Home

☐ Hospital_____ Inpt Location: Phone Ext:

- ☐ **Left Heart Catheterization**
- ☐ **Left and Right Heart Study**
- ☐ **Right Heart Study**
- ☐ **Biopsy**

Reasons for Referral: Primary reason for the patient's referral is required. Indicate the appropriate reason by adding a P beside your selection to indicate Primary Reason for Referral, and S, if applicable, to indicate one Secondary Reason for Referral.

Coronary Disease:
- ◯ Stable Angina (or Equivalent)
- ◯ Unstable Angina (or Equivalent)
- ◯ Non-ST-Segment Elevation Myocardial Infarction (NSTEMI)
- ◯ ST-Segment Elevation Myocardial Infarction (STEMI)

Valve Disease:
- ◯ Aortic Stenosis
- ◯ Aortic Regurgitation
- ◯ Other Valvular

Arrhythmia:
- ◯ Atrial Flutter
- ◯ Atypical Atrial Flutter
- ◯ Atrioventricular Nodal Re-entrant Tachycardia (AVNRT)
- ◯ Atrial Tachycardia
- ◯ Paroxysmal Atrial Fibrillation
- ◯ Persistent Atrial Fibrillation
- ◯ Ventricular Fibrillation
- ◯ Ventricular Tachycardia
- ◯ Wolff-Parkinson-White Syndrome

- ☐ **Cardiomyopathy**
- ☐ **Congenital/Structural**
- ☐ **Heart Failure**

Heart Transplant:
- ◯ Donor
- ◯ Recipient

Other:
- ◯ Heart Disease of Other Etiology
- ◯ Protocol (Research/Employment)
- ◯ Syncope

Additional Notes:

History of PVD: ◯ Yes ◯ No

History of Cerebral Vascular Disease (CVD): ◯ Yes ◯ No

Anticoagulant:
- ☐ Coumadin
- ☐ Heparin
- ☐ LMWH
- ☐ Apixaban
- ☐ Edoxaban
- ☐ Dabigatran
- ☐ Rivaroxaban

Diagnostic Information

Height: _____ cm

Weight: _____ kg

History of Myocardial Infarction: ◯ Recent (≤30 days) ◯ History (>30 days) ◯ No

History of CABG Surgery: ☐ Yes ☐ No
Where: When:

Serum Creatinine:
_____ µmol/L

History of Congestive Heart Failure: ☐ Yes ☐ No

History of previous angioplasty: ☐ Yes ☐ No
Where: When:

Canadian Cardiovascular Society Classification:
☐ 0 ☐ I ☐ II ☐ III ☐ IV

Acute Coronary Syndrome Classification:
☐ Low Risk ☐ Intermediate Risk
☐ High Risk ☐ Emergent

☐ Cardiogenic Shock

Rest ECG Ischemic Changes:
- ☐ Persistent (Fixed)
- ☐ Transient without Pain
- ☐ Transient with Pain
- ☐ Uninterpretable
- ☐ No

Exercise ECG Risk:
- ☐ Low Risk
- ☐ High Risk
- ☐ Uninterpretable
- ☐ Not Done

Functional Imaging Risk:
- ☐ Low Risk
- ☐ High Risk
- ☐ Uninterpretable
- ☐ Not Done

Referring Physician Signature:	Date: YYYY-MM-DD