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

Coronary Angiogram Referral Form

Please fax to (705) 256-3491

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:**

Race: Race is self-identified by the patient. Patient may identify as one or more option.

☐ Black ☐ East/Southeast Asian ☐ Indigenous (First Nations, Métis, Inuk/Inuit) ☐ Latino ☐ Middle Eastern ☐ South Asian ☐ White ☐ Other

The following options cannot be indicated with any other option: ☐ Unknown ☐ Prefer Not to Answer ☐ Not Collected

Referral Information

Referring Physician: Name and/or CPSO Number

Wait Location: Indicate Hospital name OR select a location

☐ Home ☐ Rehabilitation Facility ☐ Medical Facility Outside of Province ☐ Medical Facility Outside of Country

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 Regurgitation
__ Aortic Stenosis
__ 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

Allergies:

Anticoagulants:

Additional Notes:

Diagnostic Information

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

History of Percutaneous Coronary Intervention:
☐ Yes ☐ No

History of CABG Surgery:
☐ Yes ☐ No

Serum Creatinine:
_____ µmol/L

Height:
_____ cm

Weight:
_____ kg

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

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

☐ Cardiogenic Shock

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

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

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

Referring Physician Signature:

Date: YYYY-MM-DD