Ontario Health
CorHealth Ontario

Coronary Angiogram Referral Form

Please fax the referral to 705-256-3491

Sault Area Hospital
Hôpital de Sault-Sainte-Marie

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:**

Language of Preference:

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 In Ontario – Name: _____ ☐ 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)
- ☐ R/O CAD

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

Comorbidity Assessment:
- ☐ Dialysis
- ☐ Diabetes
- ☐ Cerebral Vascular Disease(CVD)
- ☐ Peripheral Vascular Disease(PVD)
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ COPD
- ☐ Dye Allergy
- ☐ Anticoagulant
  - ☐ Coumadin ☐ Heparin ☐ LMWH
  - ☐ Dabigatran ☐ If Other _____

Additional Notes:

Diagnostic Information

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

History of Congestive Heart Failure:
☐ 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 ☐ High Risk ☐ Intermediate 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