SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

PEDIATRIC CARDIOLOGY REFERRAL & TESTING FORM

Please fax completed forms to Dr. Penslar of KW Cardio-Pulmonary Services: (519) 741-5772

Date: (yyyy/mm/dd) _____ ☐ Referral for Consultation ☐ Requisition for echocardiogram only

Referring Physician: _____ ☐ Interpreter required

Physician Signature: _____ → Language: _____

Phone: _____ (ext) _____ ☐ CAS / FACS Involvement – (case manager & contact information)

Fax: _____ _____

OHIP Billing Number: _____ _____

Parent or Guardian Name: _____ **Email:** _____

Current Medication List: ☐ Faxed with Referral **Current Allergy List:** ☐ Faxed with Referral

Reason(s) for Referral (Please select all that apply)

Murmur: Grade _____ /6 ☐ systolic ☐ diastolic
Palpitations: ☐ at rest ☐ with exertion
Chest pain: ☐ at rest ☐ with exertion
Syncope: ☐ at rest ☐ with exertion
Pre-syncope: ☐ at rest ☐ with exertion
SOB/dyspnea: ☐ at rest ☐ with exertion
☐ **Kawasaki**: Diagnosis Date: _____ (yyyy/mm/dd)
→ Treated with IVIG ☐ Yes ☐ No

If any of the 5 issues listed below apply, details must be included with this referral

☐ Abnormal ECG (strips must be faxed) _____
_____
☐ Known cardiac disease *(specify)* _____
☐ Syndromes/Dysmorphisms *(specify)* _____
☐ Family History of congenital cardiac defects *(relationship and diagnosis)* _____
☐ Family History of sudden death *(relationship, age, cause)*
_____

Details of Referral: (frequency of symptoms and other signs and symptoms) _____

TO BE COMPLETED BY CARDIOLOGIST

☐ Declined ☐ ECG ☐ Urgent (less than 30 d)
☐ Accepted for consult ☐ Echo ☐ Semi-urgent (less than 90 d)
☐ Accepted for testing only ☐ Holter ____ hrs ☐ Elective

Notes: _____

Signature: _____ Date: _____ (yyyy/mm/dd)
Print Name: _____