

BC Cardiac Catheterization Referral Form

<input type="checkbox"/> First Available Site	Tel	Fax	Patient Name _____
<input type="checkbox"/> Kelowna General Hospital	250.862.4358	250.862.4453	DOB _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Royal Columbian Hospital	604.520.4519	604.520.4002	PHN _____
<input type="checkbox"/> Royal Jubilee Hospital	250.370.8439	250.370.8918	Address _____ City _____
<input type="checkbox"/> St. Paul's Hospital	604.806.8051	604.806.8637	Prov _____ Postal Code _____
<input type="checkbox"/> Vancouver General Hospital	604.875.4669	604.875.5142	Patient Information or Label / Addressograph

Information marked with *is mandatory

REFERRAL DATE*		Referring Physician		Referring Telephone		
→ FAX Referral Form, History/Consult, ECG, lab results, MAR and Echo to Requested Hospital						
PATIENT LOCATION*	<input type="checkbox"/> Hospital (Inpatient) _____ Unit _____ Unit phone # _____			<input type="checkbox"/> Home (Outpatient)		
URGENCY*	<input type="checkbox"/> Emergent → For emergent cases please phone the on-call Interventionalist at the requested hospital <input type="checkbox"/> Urgent In-Hospital (24 to 48 hrs; max 5 days) <input type="checkbox"/> Urgent Out of Hospital (within 2 wks) <input type="checkbox"/> Elective (within 6 wks)					
ALLERGIES	<input type="checkbox"/> No Known <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Contrast <input type="checkbox"/> ASA <input type="checkbox"/> Other _____					
PROCEDURE REQUESTED*	<input type="checkbox"/> Diagnostic Cath <input type="checkbox"/> Cath +/- PCI <input type="checkbox"/> PCI (planned PCI)	<input type="checkbox"/> Right Heart Cath <input type="checkbox"/> TAVI workup <input type="checkbox"/> Pulmonary Resistance	<input type="checkbox"/> Aortogram <input type="checkbox"/> Myocardial Biopsy <input type="checkbox"/> Other _____	<input type="checkbox"/> 1 st Available Physician <input type="checkbox"/> Specific Physician _____		
INDICATION*	<input type="checkbox"/> STEMI → If Fibrinolysis: Date _____ Time _____ <input type="checkbox"/> NSTEMI → <input type="checkbox"/> Ischemic ECG changes (ST or T) → <input type="checkbox"/> Positive troponin/marker Result _____ <input type="checkbox"/> Unstable Angina → Current Symptoms: <input type="checkbox"/> Ongoing <input type="checkbox"/> Re-MI <input type="checkbox"/> Recurrent Pain <input type="checkbox"/> CHF <input type="checkbox"/> Arrhythmia <input type="checkbox"/> None <input type="checkbox"/> Stable Angina <input type="checkbox"/> Arrhythmia → <input type="checkbox"/> Aortic _____ <input type="checkbox"/> Heart Failure → <input type="checkbox"/> Mitral _____ <input type="checkbox"/> Cardiomyopathy → <input type="checkbox"/> Other _____					
CURRENT MEDICATIONS	<input type="checkbox"/> IV Inotropes <input type="checkbox"/> IV Nitroglycerin <input type="checkbox"/> IV IIb/IIIa <input type="checkbox"/> IV Heparin	<input type="checkbox"/> LMWH <input type="checkbox"/> Insulin <input type="checkbox"/> Metformin	<input type="checkbox"/> ASA <input type="checkbox"/> Clopidogrel <input type="checkbox"/> Ticagrelor <input type="checkbox"/> Dabigatran	<input type="checkbox"/> Prasugrel <input type="checkbox"/> Other _____	<input type="checkbox"/> Warfarin → <input type="checkbox"/> Will hold prior to procedure → <input type="checkbox"/> Will require bridging therapy → <input type="checkbox"/> Perform on Anticoagulation	
CO-MORBIDITIES	<input type="checkbox"/> Hypertension <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Diabetes <input type="radio"/> Type I <input type="radio"/> Type II <input type="checkbox"/> Smoking <input type="radio"/> Current <input type="radio"/> Former <input type="checkbox"/> COPD <input type="checkbox"/> Prior MI <input type="checkbox"/> Prior PCI <input type="checkbox"/> Prior OHS <input type="radio"/> CABG <input type="radio"/> Valve					
	<input type="checkbox"/> Cerebrovascular Event <input type="radio"/> Prior Stroke <input type="radio"/> Prior TIA <input type="checkbox"/> Renal Insufficiency <input type="radio"/> Acute <input type="radio"/> Chronic <input type="checkbox"/> Dialysis <input type="radio"/> HD <input type="radio"/> PD <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> History of Heart Failure <input type="checkbox"/> Suspected LV Thrombus <input type="checkbox"/> GI Bleed within 1 year <input type="checkbox"/> Other _____					
CCS ANGINA CLASS*	Within 2 weeks <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> IVa <input type="checkbox"/> IVb <input type="checkbox"/> IVc					
NYHA CLASS*	Within 2 weeks <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> n/a					
PRIOR NON-INVASIVE TESTS	<input type="checkbox"/> Exercise Stress Test Date _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> MIBI <input type="checkbox"/> Other _____ Date _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate				LVEF _____ % Source _____	
LAB VALUES*	Creatinine* _____ Hgb* _____ WBC _____ Troponin _____ eGFR _____ Platelets _____ INR _____ Other _____					
HEIGHT/WEIGHT	Height _____ cm		Weight _____ kg			
SPECIAL INSTRUCTIONS/ BRIEF HISTORY						
Referring Physician's Signature*		Accepting Physician's Signature		Acceptance Date (dd/mm/yyyy)		

