PRINT CLEAR FORM

Providence Health Care
Heart Centre

CARDIAC OBSTETRICS CLINIC REFERRAL

* 1 0 4 9 5 *

Cardiology Referral

Date of Referral: _____ ****FOR URGENT REQUESTS** (for inpatients admissions and referrals more than 34 weeks gestation) **contact VPACH physician on call (604-682-2344)**

PATIENT INFORMATION		
Name: (last, first)		**Contact information:**
Former name/maiden name:		Home telephone: _____
Address:		Cell: _____
City:	Postal Code:	Email: _____
DOB: (dd/mmm/yyyy)	PHN:	☐ Interpreter required
Alternative contact: (name)		Language: _____
Relationship to patient:	Telephone:	
If pregnant, estimated date of delivery:		

REASON FOR REFERRAL

- ☐ Congenital Heart Disease: _____
- ☐ Acquired Heart Disease: _____
- ☐ Pre pregnancy counseling: _____
- ☐ palpitations NYD : ** please arrange Holter monitor prior to referring patient _____
- ☐ Other cardiac condition: _____

Symptoms: (details) _____

REFERRING CLINICIAN		
Name:	Specialty:	MSP number:
Address:		
Telephone:	Fax:	

PRIMARY OBSTETRIC CARE PROVIDER	
Name:	MSP number:
Address:	
Telephone:	Fax:

COMPLETED TESTS and ASSESSMENTS (please include copies in referral)**:**

☐ Cardiac Echocardiogram ☐ ECG ☐ Historical cardiac assessments/documents
☐ Obstetrical Ultrasound ☐ Fetal Echocardiogram ☐ Antenatal records ☐ Holter Monitor

OTHER RELEVANT INFORMATION

Medications: _____

Allergies: _____

Other: _____

*****Please refer early to allow time for diagnostics, appointments and care planning.**

Newly diagnosed murmurs must have echo imaging completed prior to referral. Palpitations NYD must have Holter monitor completed prior to referral.

PLEASE FAX INFORMATION TO: **Cardiac Obstetrics Clinic (COB)** St. Paul's Hospital **Fax: 604-602-8643**
5051-1081 Burrard St, Vancouver, BC V6Z 1Y6
Telephone: 604-806-8520 Ext. 5 Email: SPHCOB@providencehealth.bc.ca