fraserhealth

Outpatient Cardiac Catheterization Referral

FRASER HEALTH Central Cath Lab
Bookings & Triage Office
Bookings - 604.520.4519
Fax- 604.520.4002

CDXX106451A Rev:

Date: _____

Referring Physician: _____

Referring Telephone: _____

Referring Fax: _____

Family MD: _____

Pt. Name _____

DOB: ___/___/____ (dd/mm/yyyy) Sex: ☐ M ☐ F

PHN: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Phone: Home: _____ Cell/Work: _____

URGENCY

☐ **Urgent** (< 2 weeks) ☐ **Elective**

PROCEDURE REQUESTED

☐ Diag. Left Heart Cath ☐ Left Heart Cath +/- PCI
☐ Right Heart Cath ☐ PCI only
☐ Aortogram ☐ Myocardial Biopsy
☐ Structural Heart Disease Intervention
☐ Peripheral angio/angioplasty
☐ Other: _____

☐ 1st Available Cardiologist _____

☐ Preferred Interventional Cardiologist _____

ALLERGIES

☐ No Known ☐ Contrast
☐ ASA ☐ Local Anesthetic ☐ Plavix ☐ Other

INDICATION

☐ Stable Ischemic Heart Disease
☐ Valvular Heart Disease
- ☐ Aortic _____
- ☐ Mitral _____
- ☐ Other _____

☐ CHF / Cardiomyopathy
☐ Arrhythmia ☐ Research Protocol
☐ Congenital
☐ Other: _____

PRECEDING TESTS

☐ Exercise Stress Test DATE: _____
Result: ☐ Strongly Positive ☐ Positive ☐ Negative ☐ Equivocal

☐ Functional Imaging (MPI / Stress ECHO) DATE: _____
Result: ☐ Strongly Positive ☐ Positive ☐ Negative ☐ Equivocal

☐ CT Angio DATE: _____
Result: ☐ SVD, 2VD or 3VD ☐ Positive ☐ Negative ☐ Equivocal

☐ ECHO DATE: _____
LVEF _____ % Source: _____

MEDICATIONS

☐ Metformin
☐ Warfarin
Reason: _____
Last Dose: _____
☐ Dabigatran
☐ Other:

LAB VALUES

INR _____ Hgb _____
Ptt _____ Cr _____
eGFR _____
Other _____

CCS Angina Class

☐ 0 ☐ I ☐ II ☐ III ☐ IV

NYHA Class

☐ I ☐ II ☐ III ☐ IV

CO-MORBIDITIES

☐ Hypertension
☐ Diabetes ☐ NIDDM ☐ IDDM
☐ Smoking ☐ Current ☐ Former
☐ Hyperlipidernia
☐ Cerebral Vascular Disease ☐ Current ☐ History of
☐ Peripheral Vascular Disease
☐ Anemia/ GI bleed ☐ Current ☐ History of
☐ Renal Insufficiency ☐ Acute ☐ Chronic
☐ Dialysis
☐ CHF ☐ Current ☐ History of
☐ Prior MI
☐ Prior PCI
☐ Prior OHS ☐ CABG ☐ Valve
☐ COPD
☐ Other _____

COMMENTS:

For booking office only:
Procedure Decision Date (dd/mm/yyyy) _____ Cath Procedure Date (dd/mm/yyyy) _____

Fax Referral Form, Consult / History, ECG, Lab Results, Echo, Stress Test
To: ROYAL COLUMBIAN HOSPITAL, CARDIAC CATHETERIZATION LAB, FAX# (604) 520-4002