



# Outpatient Cardiac Catheterization Referral

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

CDXX106451A

Rev:

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Date: _____	Pt. Name _____
Referring Physician: _____	DOB: <u>  </u> / <u>  </u> / <u>  </u> Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Referring Telephone: _____	PHN: _____
Referring Fax: _____	Address: _____
Family MD: _____	City: _____ Prov: _____ Postal Code: _____
	Phone: Home: _____ Cell/Work: _____

## URGENCY

Urgent (< 2 weeks)

Elective

### PROCEDURE REQUESTED

- |  |  |
|--|--|
| <input type="checkbox"/> Diag. Left Heart Cath                 | <input type="checkbox"/> Left Heart Cath +/- PCI |
| <input type="checkbox"/> Right Heart Cath                      | <input type="checkbox"/> PCI only                |
| <input type="checkbox"/> Aortogram                             | <input type="checkbox"/> Myocardial Biopsy       |
| <input type="checkbox"/> Structural Heart Disease Intervention |  |
| <input type="checkbox"/> Peripheral angio/angioplasty          |  |
| <input type="checkbox"/> Other: _____                          |  |

- 1st Available Cardiologist \_\_\_\_\_
- Preferred Interventional Cardiologist \_\_\_\_\_

### ALLERGIES

- No Known  Contrast
- ASA  Local Anesthetic  Plavix  Other

### INDICATION

- Stable Ischemic Heart Disease
- Valvular Heart Disease
- |                                       |       |
|---------------------------------------|-------|
| <input type="checkbox"/> Aortic _____ | _____ |
| <input type="checkbox"/> Mitral _____ | _____ |
| <input type="checkbox"/> Other _____  | _____ |
- CHF / Cardiomyopathy
- Arrhythmia  Research Protocol
- Congenital
- Other: \_\_\_\_\_

### MEDICATIONS

- Metformin
- Warfarin  
Reason: \_\_\_\_\_  
Last Dose: \_\_\_\_\_
- Dabigatran
- Other: \_\_\_\_\_

### CO-MORBIDITIES

- Hypertension
- Diabetes  NIDDM  IDDM
- Smoking  Current  Former
- Hyperlipidemia
- 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 \_\_\_\_\_

### LAB VALUES

INR \_\_\_\_\_ Hgb \_\_\_\_\_

Ptt \_\_\_\_\_ Cr \_\_\_\_\_

eGFR \_\_\_\_\_

Other \_\_\_\_\_

### CCS Angina Class

0  I  II  III  IV

### NYHA Class

I  II  III  IV

### 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: \_\_\_\_\_

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