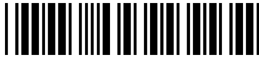
OUTPATIENT CARDIAC CATHETERIZATION REFERRAL

Cardiac Services



Form ID: CDXX106451C Rev: August 7, 2024

Fraser Health Central Cath Lab Bookings and Triage Office
Phone: 604-520-4519 Fax: 604-520-4002

Instructions: To be filled out by referring physician

Date (DD/MM/YYYY) and time:	**Urgency:** ☐ Urgent (less than two weeks) ☐ Elective
Referring physician:	Signature:
Referring telephone:	Referring fax:

Family physician or nurse practitioner:

☐ First available RCH cardiologist:

☐ Preferred interventional cardiologist:

Allergies: ☐ ASA ☐ Local anesthetic ☐ Plavix ☐ Contrast ☐ None known ☐ Other:

Procedure requested:	☐ Diagnostic left heart cath ☐ Structural heart disease intervention ☐ Peripheral angio or angioplasty ☐ Left heart cath +/- PCI ☐ PCI only ☐ Myocardial biopsy ☐ Right heart cath ☐ Aortogram
Medications:	☐ ASA ☐ Clopidogrel ☐ Ticagrelor ☐ Low-Molecular-Weight Heparin (LMWH) ☐ Metformin ☐ Warfarin ☐ Dabigatran or Rivaroxaban ☐ Apixaban or Edoxaban
Comorbidities:	☐ Hypertension ☐ Hyperlipidernia ☐ Peripheral vascular disease ☐ Dialysis ☐ Prior MI ☐ Prior PCI ☐ COPD ☐ Other: ____ ☐ Diabetes: If yes, ☐ NIDDM ☐ IDDM ☐ Smoking: If yes, ☐ Current ☐ Former ☐ Cerebral vascular disease: If yes, ☐ Current ☐ History of ☐ Anemia or GI bleed: If yes, ☐ Current ☐ History of ☐ Renal insufficiency: If yes, ☐ Acute ☐ Chronic ☐ Congestive heart failure (CHF): If yes, ☐ Current ☐ History of ☐ Prior OHS: If yes, ☐ CABG ☐ Valve
Indication:	☐ Stable ischemic heart disease ☐ Valvular heart disease ☐ Aortic ☐ Mitral ☐ Other ☐ CHF or cardiomyopathy ☐ Arrhythmia ☐ Congenital ☐ Research protocol ☐ Other: ____
Preceding tests:	☐ Exercise Stress Test: ☐ Strongly positive ☐ Positive ☐ Negative ☐ Equivocal Date (DD/MM/YYYY): ____ ☐ Functional Imaging (Myocardial perfusion imaging or Stress ECHO): ☐ Strongly positive ☐ Positive ☐ Negative ☐ Equivocal Date (DD/MM/YYYY): ____ ☐ CT Angio: ☐ Single Vessel Disease (VD), 2VD, or 3VD ☐ Positive ☐ Negative ☐ Equivocal Date (DD/MM/YYYY): ____ ☐ Echo: ☐ LVEF: ____ % ☐ Source Date (DD/MM/YYYY): ____

Canadian Cardiovascular Society (CCS) angina class: ☐ 0 ☐ II ☐ III ☐ IV

NYHA class: ☐ I ☐ II ☐ III ☐ IV

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

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Sample Form - for Education Purposes Only