Ontario Health
CorHealth Ontario

CORONARY ANGIOGRAM REFERRAL FORM

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Instructions: Fax to **WRH Cardiac Cath Lab 519-973-5584**. Do NOT send to CorHealth Ontario. Select only one option, unless noted otherwise.

Physician Information

Name of Referring Physician and/or CPSO Number:

Name of GP/ Family Physician:

Name of Requested Procedural Physician:

Language of Preference:

Patient Information

Patient Name:

DOB (YYYY-MM-DD)**:**

MRN:

Health Card Number:

Patient Address:

Primary Phone:

Alternate Phone:

Referral Information

Wait Location: Indicate Hospital name OR select a location

☐ Home ☐ Elective ☐ Within 2 weeks ☐ Hospital _____ ☐ Unit_____
☐ Rehabilitation Facility ☐ Medical Facility Outside of Province ☐ Medical Facility Outside of Country

Reasons for Referral: Primary reason for the patient's referral is required. Indicate the appropriate reason by adding a P beside your selection to indicate Primary Reason for Referral, and S, if applicable, to indicate one Secondary Reason for Referral.

Coronary Disease:

__ Stable Angina (or Equivalent)
__ Unstable Angina (or Equivalent)
__ Non-ST-Segment Elevation Myocardial Infarction (NSTEMI)
__ ST-Segment Elevation Myocardial Infarction (STEMI)

Valve Disease:

__ Aortic Regurgitation
__ Aortic Stenosis
__ Other Valvular

Arrhythmia:

__ Atrial Flutter
__ Atypical Atrial Flutter
__ Atrioventricular Nodal Re-entrant Tachycardia (AVNRT)
__ Atrial Tachycardia
__ Paroxysmal Atrial Fibrillation
__ Persistent Atrial Fibrillation
__ Ventricular Fibrillation
__ Ventricular Tachycardia
__ Wolff-Parkinson-White Syndrome

__ **Cardiomyopathy**
__ **Congenital/Structural**
__ **Heart Failure**

Heart Transplant:

__ Donor
__ Recipient

Other:

__ Heart Disease of Other Etiology
__ Protocol (Research/Employment)
__ Syncope

Additional Notes:

Diagnostic Information

History of Myocardial Infarction:
☐ Recent (≤30 days) ☐ History (>30 days) ☐ No

History of Congestive Heart Failure:
☐ Yes ☐ No

History of CABG Surgery: ☐ Yes ☐ No

Previous PCI: ☐ Yes ☐ No

Laboratory:
Serum Creatinine _____ µmol/L
Hemoglobin _____g/L

Height: _____ cm
Weight: _____ kg

Anticoagulation: ☐ Yes ☐ No
Dye Allergy: ☐ Yes ☐ No
Dialysis: ☐ Yes ☐ No

Canadian Cardiovascular Society Classification:
☐ 0 ☐ I ☐ II ☐ III ☐ IV

Acute Coronary Syndrome Classification:
☐ Low Risk ☐ Intermediate Risk
☐ High Risk ☐ Emergent

☐ Cardiogenic Shock

Exercise ECG Risk:
☐ Low Risk
☐ High Risk
☐ Uninterpretable
☐ Not Done

Rest ECG Ischemic Changes:
☐ Persistent (Fixed)
☐ Transient without Pain
☐ Transient with Pain
☐ Uninterpretable
☐ No

Functional Imaging Risk:
☐ Low Risk
☐ High Risk
☐ Uninterpretable
☐ Not Done

Referring Physician Signature:

Date: (YYYY-MM-DD)