BC Cardiac Catheterization Referral Form

	Tel	Fax
☐ Kelowna General Hospital	250.862.4358	250.862.4453
☐ Royal Columbian Hospital	604.520.4519	604.520.4002
☐ St. Paul's Hospital	604.806.8051	604.806.8637
☐ Royal Jubilee Hospital	250.370.8439	250.370.8006
☐ Vancouver General Hospital	604.875.4669	604.875.5142

Patient Name _____

PHN _____

DOB *(dd/mm/yyyy)* _____ / _____ / _____ Sex ☐ M ☐ F

Address _____

City _____ Prov _____ Postal Code _____

Tel *(home)* _____ *(work)* _____

*Information marked with * is mandatory.*

REFERRAL DATE*	Referring Physician	Referring Telephone

➡ FAX Referral Form, History / Consult, ECG, lab results, MAR and Echo to Requested Hospital

PATIENT LOCATION*

☐ Hospital (Inpatient) _____ Unit _____ Unit phone # _____ ☐ Home (Outpatient)

URGENCY*

☐ **Emergent** → For emergent cases please phone the on-call Interventionalist at the requested hospital
☐ **Urgent In-Hospital** (24 to 48 hrs; max 5 days) ☐ **Urgent Out of Hospital** (within 2 wks) ☐ **Elective** (within 6 wks)

ALLERGIES

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

PROCEDURE REQUESTED*

☐ Diagnostic Cath ☐ Right Heart Cath ☐ Aortogram ☐ 1st Available Physician
☐ Cath +/- PCI ☐ TAVI Workup ☐ Myocardial Biopsy ☐ Specific Physician _____
☐ PCI (planned PCI) ☐ Pulmonary Resistance ☐ Other _____

INDICATION*

☐ STEMI → If Fibrinolysis: *date* _____ *time* _____
☐ NSTEMI → ☐ Ischemic ECG changes (ST or T) → ☐ Positive troponin / marker *Result* _____
☐ Unstable Angina → Current Symptoms: ☐ Ongoing ☐ Re-MI ☐ Recurrent Pain ☐ CHF ☐ Arrhythmia ☐ None
☐ Stable Angina
☐ Arrhythmia
☐ Heart Failure
☐ Cardiomyopathy

☐ Valvular Heart Disease
→ Aortic _____
→ Mitral _____
→ Other _____

☐ Congenital
☐ Transplant: ○ Pre ○ Post
☐ Research
☐ Other _____

CURRENT MEDICATIONS

☐ IV Inotropes ☐ LMWH ☐ ASA ☐ Warfarin
☐ IV Nitroglycerin ☐ Insulin ☐ Clopidogrel ☐ Prasugrel → ☐ Will hold prior to procedure
☐ IV IIb / IIIa ☐ Metformin ☐ Ticagrelor ☐ Other _____ → ☐ Will require bridging therapy
☐ IV Heparin ☐ Dabigatran → ☐ Perform on Anticoagulation

CO-MORBIDITIES

☐ Hypertension
☐ Dyslipidemia
☐ Diabetes: ○ Type I ○ Type II
☐ Smoking: ○ Current ○ Former
☐ COPD
☐ Prior MI
☐ Prior PCI
☐ Prior OHS: ○ CABG ○ Valve

☐ Cerebrovascular Event: ○ Prior Stroke ○ Prior TIA
☐ Renal Insufficiency: ○ Acute ○ Chronic
☐ Dialysis: ○ HD ○ PD
☐ Peripheral Vascular Disease
☐ History of Heart Failure
☐ Suspected LV Thrombus
☐ GI Bleed within 1 year
☐ Other _____

CCS ANGINA CLASS* within 2 weeks ☐ I ☐ II ☐ III ☐ IV ☐ IVa ☐ IVb ☐ IVc

NYHA CLASS* within 2 weeks ☐ I ☐ II ☐ III ☐ IV ☐ n/a

PRIOR NON-INVASIVE TESTS

☐ Exercise Stress Test Date _____ Result: ☐ Positive ☐ Negative ☐ Indeterminate **LVEF** _____%
☐ MIBI Other _____ Date _____ Result: ☐ Positive ☐ Negative ☐ Indeterminate Source _____

LAB VALUES* Creatinine* _____ Hgb* _____ WBC _____ Troponin _____ eGFR _____ Platelets _____ INR _____ Other _____

HEIGHT / WEIGHT Height _____ cm Weight _____ kg

SPECIAL INSTRUCTIONS / BRIEF HISTORY

Referring Physician's Signature*	Accepting Physician's Signature	Acceptance Date *(dd/mm/yyyy)*
		/ /

Interior Health · fraserhealth · island health · Providence HEALTH CARE · Vancouver CoastalHealth *Promoting wellness. Ensuring care.* · northern health *the northern way of caring*