SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9
southlake.ca

Cardiac Surgery Referral Form

Fax to Cardiac Surgery Triage Coordinator 905-952-2445

Patient Information

First Name:	**Middle Name:**	**Last Name:**	
Health Card Number:	**Version Code:**	**Date of Birth:** yy / mm / dd	**MRN:**
Street Address:	*Suite:*	*City:*	
Province/State:	*Postal/Zip Code:*	*Country:*	
Primary Phone: ( )	**Alternate Phone:** ( )	**Language of Preference:**	

Referral Information

Referring Physician Name:	**Requested Procedural Surgeon Name:** ☐ **or 1st available**
Address:	
Phone: ( )	**Fax:** ( )
Billing Number:	

Wait Location: ☐ Home ☐ Hospital *(please indicate)*: _____ ☐ Out of province ☐ Out of country

Reason for Referral

Surgical:
- ☐ CABG
- ☐ CABG & Valve
- ☐ Valve ONLY
- ☐ Aortic Operation
- ☐ Congenital/Structural

Primary Reason:
- ☐ Coronary Disease
  - ☐ Stable Angina
  - ☐ Unstable Angina
  - ☐ NSTEMI
  - ☐ STEMI
- ☐ Valve Disease
  - ☐ Aortic Stenosis
  - ☐ Aortic Regurgitation
  - ☐ Mitral Stenosis
  - ☐ Mitral Regurgitation
- ☐ Other _____

Secondary Reason:
- ☐ Heart Failure
- ☐ Cardiomyopathy
- ☐ Arrhythmia
- ☐ Heart Transplant
- ☐ Other: _____
  Disease of Other Etiology

Additional Notes *(please fax additional investigative information such as consult notes, echo, functional imaging, recent blood work)*:

Diagnostic Information

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

History of Congestive Heart Failure: ☐ No ☐ Yes

History of CABG Surgery: ☐ No ☐ Yes

History of PCI: ☐ No ☐ Yes

LVEF ____% or:
☐ I (≥ 50%) ☐ II (35%-49%) ☐ III (20-34%) ☐ IV (<20%)

NYHA: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Cath Location: _____

Date of Cath: yy / mm / dd ☐ pending

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

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

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

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

Referring Physician Signature: **Date**: yy / mm / dd