SouthlakeHealth

596 Davis Drive
Newmarket, ON L3Y 2P9

East Level 2
(905) 895-4521 ext 6500

Health Record #: _____ Complete or place barcoded patient label here

Patient Name: (Print first, last) _____

DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: dd / mm / yy

ED Urgent Cardiology Clinic Referral

❑ **EMERGENCY DEPARTMENT**

Please fax to 905-952-2467

PLEASE COMPLETE FORM

Patient Name: *(print first, last)*

Address: Street Number and Name | Apartment | City | Province | Postal Code

Contact #:	**Alternate #:**

Referring Physician: *(print first, last)*	**Phone:** ( )	**Fax:** ( )

Referral Criteria *(please select one)*

❑ CHEST PAIN - suspected or recurrent angina (ccs 1-3) without any acute high risk features

❑ DYSPNEA WITH SUSPECTED CONGESTIVE HEART FAILURE

- **NYHA CLASS I-III symptoms, presence of orthopnea, PND and/or edema, elevated BNP**
- **Dyspnea and significant structural heart disease (reduced systolic function, diastolic dysfunction, severe LVH, moderate or severe valve pathology)**

❑ SYNCOPE

❑ PALPITATIONS/SIGNIFICANT ARRHYTHMIAS

❑ PERICARDIAL EFFUSION - new incidental finding or follow-up assessment

Relevant History _____

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INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION

Referring Physician's Signature:	**Billing #:**	**Date:** dd / mm / yy

OFFICE USE ONLY – Referral Received: dd / mm / yy	**Appointment Date:** dd / mm / yy	**Patient Notified:** ❑ Yes ❑ No

The collecting of personal information on this form is done in accordance with Southlake Health's Privacy Policy. Details regarding this Policy are available on our website, www.southlake.ca.

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