



Leading Edge Care. Close to Home.

596 Davis Drive
Newmarket, ON L3Y 2P9
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

Hypertrophic Cardiomyopathy Clinic Referral

Please fax to 905-952-2467

To avoid delays in booking please ensure clinic notes, prior echo reports and other relevant diagnostic test results are included. Incomplete requisitions will be returned to referring provider for completion.

Patient Name: (print first, last)					Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>	
Address: <u>Street Number + Name</u>		<u>Apartment</u>		<u>City</u>		<u>Province</u>
<u>Postal Code</u>		Health Card Number:		Version Code:		
Contact Number: ()		Alternate Phone: ()				

REASON FOR REFERRAL

Cardiologist referrals only

Suspected HCM

Known HCM

Obstructive Nonobstructive

Apical Undetermined

Screening (family history of HCM or SCD)

Genetic testing

HCM management

Septal reduction treatment

ASA Myectomy

Initiation of advanced pharmacologic therapy (e.g., CMI)

Other *(provide details):* _____

REQUIRED TESTING

Echocardiogram Bloodwork

Cardiac MRI Genetic testing

ECG Other:

Stress test

Holter monitor

Stress Echo

CURRENT HCM TREATMENT

None Cardiac myosin inhibitor

Beta blocker Myectomy or ablation

Calcium channel blocker Other:

Disopyramide

OTHER PERTINENT INFORMATION

Please submit all pertinent clinical notes, cardiac investigations (ECG, stress test, echocardiogram, etc.), bloodwork, and other relevant information with completed referral form to the entity you are referring to.

Referring Physician: <i>(print first, last)</i>		Billing #:	
Signature:		Date: <u>dd</u> / <u>mm</u> / <u>yy</u>	
Office Phone: ()		Fax Number: ()	
COPY OF REPORT TO: Family Doctor: _____			

OFFICE USE ONLY Date of Appointment: dd / mm / yy

