PEDIATRIC CARDIOLOGY & ECHOCARDIOGRAM REFERRAL

McMaster Children's Hospital

Contact booking desk at **905-521-2100 x 73974** for any further questions

Please fax completed forms to:

905-521-5056

M#: _____

Patient Information

Name: _____

DOB: _____ _____Male _____Female

Health Card #:_____ (OHIP)

Address: _____

City: _____ Postal Code: _____

Telephone: _____ Cellular: _____

Interpreter required: _____

CAS/FACS involvement: _____

Family Physician: _____

Referring Physician Information

Name: _____

Address: _____

Postal Code: _____

Telephone: _____

Fax: _____

Physician Billing #: _____

Signature: _____

REASON(S) FOR CONSULTATION (*Please select all that apply)*

□ Murmur, Grade_____
□ Palpitations at rest
□ Palpitations with exertion
□ Chest pain at rest
□ Chest pain with exertion
□ Syncope at rest
□ Syncope with exertion
□ Pre-syncope
□ SOB/dyspnea

□ Known cardiac disease: _____
□ Syndromes/Dysmorphisms: _____
□ Abnormal ECG (**MUST BE ATTACHED**):
_____
□ Family Hx of congenital cardiac defects: _____
□ Family Hx of sudden death: _____
□ Kawasaki: _____ Treated with IVIG □ Yes □ No
□ Other: _____
_____

Details of Referral *(frequency of symptoms, other signs and symptoms):*

_____

_____

_____

Medications: _____

Please attach all supporting information and results of tests ALREADY completed.

Please note that the cardiologist will triage appointment and echocardiogram requests.

PEDIATRIC CARDIOLOGY OFFICE USE ONLY

Cardiologist's Notes: _____

_____

_____

_____

□ Dr. Almeida □ Dr. Dillenburg □ Dr. Mondal □ Dr. Predescu

□ Echo: _____ □ Holter: _____

□ EX Test: _____ □ Loop/Event: _____

□ Visit: _____

Received: _____