



# FETAL CARDIOLOGY ECHOCARDIOGRAM REFERRAL

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

Please fax completed forms to:

**905-521-5056**

Date of Referral: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Health Card #: \_\_\_\_\_ (OHIP)

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cellular: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Obstetrician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

G: \_\_\_\_\_

P: \_\_\_\_\_

A: \_\_\_\_\_

EDD: \_\_\_\_\_

GA at time of referral: \_\_\_\_\_

Twin pregnancy:  Yes  No

Interpreter required?  
If yes, please specify language: \_\_\_\_\_

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

#### Fetal:

- Abnormal cardiac morphology
- Abnormal cardiac rhythm
- TTT
- Other: \_\_\_\_\_

#### Maternal/Familial:

- Mat/Pat/Sibling with cardiac defect
- Positive Anti-Ro/SSA; Anti-La/SSB
- Drug/medication exposure: \_\_\_\_\_
- Other maternal conditions: \_\_\_\_\_
- Other familial conditions: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

### Please select and ATTACH all supporting information and results of tests already completed:

- Abnormal obstetric US findings: \_\_\_\_\_
- Anti-Ro/SSA; Anti-La/SSB titers: \_\_\_\_\_
- Amniocentesis: \_\_\_\_\_
- NIPT: \_\_\_\_\_
- Other: \_\_\_\_\_

### FETAL CARDIOLOGY OFFICE USE ONLY

Cardiologist's Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Triage Dr.:  ALMEIDA  DILLENBURG  MONDAL  PREDESCU

Received: \_\_\_\_\_ Triage Date: \_\_\_\_\_ U#M \_\_\_\_\_