McMaster Children's Hospital

PEDIATRIC CARDIOLOGY REFERRAL

Contact booking desk at **905-521-2100 x 78517** for any further questions

Please fax completed forms to:

905-521-5056

Date of Referral: ___________________________

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
- ☐ Palpitations
- ☐ Suspected cardiac chest pain
- ☐ Syncope with exertion
- ☐ Syncope at rest
- ☐ Pre-syncope
- ☐ SOB/dyspnea
- ☐ Known cardiac disease: ____
- ☐ Syndromes/Dysmorphisms: ____
- ☐ Abnormal ECG: ____
- ☐ 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):*

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Medications: ____

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

- ☐ Last clinical letter
- ☐ Echocardiogram
- ☐ Blood Work
- ☐ Exercise Test
- ☐ ECG (with tracing)
- ☐ Holter (with tracings)
- ☐ Chest X-ray
- ☐ Other: ____

PEDIATRIC CARDIOLOGY OFFICE USE ONLY

Cardiologist's Notes: ____

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☐ Echo: ________________________________ ☐ Holter: ______________________________

☐ EX Test: ______________________________ ☐ Loop/Event: __________________________

☐ Visit: ____

☐ MN PCARD ☐ MNU PCARD ☐ MNPCARDFET

Triage Dr.: ☐ ALMEIDA ☐ DILLENBURG ☐ MONDAL ☐ PREDESCU

Received: ______________________ Triage Date: _________________________ U#M__________________________