Providence Health Care

HCM AND HERITABLE CARDIOMYOPATHY CLINIC REFERRAL

Cardiology Referral

St. Paul's Hospital B480 1081 Burrard St, Vancouver, BC V6Z 1Y6
Telephone: 604-682-2344 Ext. 63284 Fax 604-602-8658

Date of Referral: (dd/mmm/yyyy) _____

☐ Urgent Referral (Will be triaged by our clinic physicians) ☐ Next available appointment

PATIENT INFORMATION		
Last name:	First name:	
Address:	City:	Postal Code:
Telephone:	Cell:	
Email:	Permission to email patient: ☐ No ☐ Yes	
DOB: (dd/mmm/yyyy)	PHN:	
Gender: ☐ Male ☐ Female ☐ Other: _____	Interpreter required: ☐ No ☐ Yes Language: _____	

REFERRING CLINICIAN		
Name:	Specialty:	MSP number:
Address:		
Telephone:	Fax:	

REASON FOR REFERRAL

Select the condition for which clinical and/or genetic assessment is being requested:

☐ Hypertrophic Cardiomyopathy (HCM) ☐ Dilated/Non-Ischemic Cardiomyopathy (DCM/NICM)

Please indicate if the patient is also being referred for advanced therapies such as septal reduction therapy and cardiac myosin inhibitors:

☐ Yes ☐ No

*All referrals **must** include a consult letter, a recent echocardiogram and ECG. Other relevant cardiology investigations (e.g., cardiac MRI, cardiac CT, cardiac cath reports) should be included.*

Incomplete referrals will not be processed.

☐ **Family history of HCM or DCM/NICM**

*For referrals based on family history of HCM or DCM, **all** the following information/documents must be provided with the referral. **Incomplete referrals will not be processed.***

☐ Full name of family member with HCM/DCM and relationship to your patient: _____

OR copy of family letter provided to patient.

☐ Genetic testing report for family member with HCM/DCM

*If genetic testing has **not** been performed in the family, and your patient has had a normal echo, testing cannot be offered to your patient. Please advise your patient to have their family member referred for genetic testing at our clinic or a local clinic first.*

☐ Echocardiogram and ECG reports for your patient.

☐ **Transition to adult care (for pediatric patients only)**

Please indicate if your patient needs to be considered for genetic counselling and testing:

☐ Yes ☐ No, patient has already completed genetic testing *(please include genetics report)*

HCM AND HERITABLE CARDIOMYOPATHY CLINIC REFERRAL **Cardiology Referral**	Place Patient Label Here

PRIOR TESTS (please include reports in referral package)		
☐ Echocardiogram	☐ Stress Test	☐ Bloodwork
☐ Cardiac MRI	☐ Holter Monitor	☐ Genetic Testing

OTHER RELEVANT INFORMATION

PLEASE FAX ALL RELEVANT DOCUMENTS WITH COMPLETED REFERRAL FORM TO

Fax: 604-602-8658