



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

Cardiovascular Integrated Physiology (CVIP) Clinic Referral OFFICE or IN-PATIENT

PLEASE COMPLETE FORM AND FAX WITH RELEVANT DOCUMENTATION TO (905) 952-2467

Patient Name: *(print first, last)* _____

Address: Street Number and Name _____ Apartment _____ City _____ Province _____ Postal Code _____

Contact Number: _____ OK to call OK to leave a message

Alternate Number: _____ OK to call OK to leave a message

Send copies to:
 Family Physician _____
 Other Doctor _____

Referring Physician: *(print first, last)* _____ **Phone:** _____

Primary Hospital Affiliation: _____ **Pager/Cell:** _____

Family Physician: *(print first, last)* _____ **Billing #:** _____

Primary Indication for Clinic Visit: *(*see reverse for definition)*
 Postural Orthostatic Tachycardia Syndrome* Syndrome X* Syndrome Y or Coronary Slow Flow Syndrome*
 Heart Failure with Preserved Ejection Fraction Takotsubo Cardiomyopathy MI with normal coronaries
 Epicardial Spasm Myocardial Bridging Other _____

Cardiac Risk Factors: Cholesterol Depression/Anxiety Hypertension Smoker
 Diabetes Disordered Sleep Obesity Positive Family History

Past Medical History and Reason for Referral: _____

Diagnostic Test Requested: ECG Exercise Stress Test Echocardiogram Holter monitor

Previously seen by a cardiologist? No Yes – **Cardiologist:** *(print first, last)* _____

*** Please enclose most recent investigations, ECG, stress test, echocardiogram, holter monitor, angiogram, other.**

Current Medications: _____

Referring Physician's Signature: _____ **Date:** dd / mm / yy

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





Health Record #:	_____	Complete or place barcoded patient label here
Patient Name:	_____ <small>(Print first, last)</small>	
DOB:	mm / dd / yy	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #:	_____	Version Code: _____
Account #:	_____	Date of Admission: mm / dd / yy

Cardiovascular Integrated Physiology (CVIP) Clinic Referral

Primary Indication for Clinic Visit – Defined

Postural Orthostatic Tachycardia Syndrome: An increase in heart rate by 30 bpm or a heart rate of 120 bpm occurring after 10 minutes of standing without evidence of orthostatic hypotension causing the person to be unable to stand or remain upright for prolonged periods of time due to light headedness, weakness, or near-syncope.

Syndrome X: The patient will typically complain of exertional chest pain. To qualify for referral they must have non-invasive evidence of ischemia and a normal coronary angiogram. Non-invasive testing must include an abnormal graded exercise test with diagnostic ECG changes. Chest pain and/or abnormal perfusion scans alone will not be sufficient.

Syndrome Y or Coronary Slow Flow Syndrome: The patient will typically complain of paroxysms of rest pain and may present with a non ST elevation MI (NSTEMI). To qualify for referral they must have angiographic evidence of slow coronary flow in the absence of significant stenoses. Slow flow is defined as Thrombolysis in Myocardial Infarction (TIMI) 1-2 flow and/or a TIMI frame count of more than 40. We will be accepting NSTEMI with normal coronaries and patients with old Kawaski's disease in this category.