McMaster Children's Hospital

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FETAL CARDIOLOGY CONSULTATION AND ECHOCARDIOGRAM REFERRAL

(For office use: accepted referrals should have Fetal Echo booked with Pediatric Cardiology visit)

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) | Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

Date: (yyyy/mm/dd) _____

Referring Physician _____

Physician's Signature _____

Phone: _____ (ext) _____

Fax: _____

Patient's M # _____

OHIP Billing Number _____

☐ Interpreter required → Language _____

Patient's Email: _____

Current Medication List: ☐ Faxed with Referral **Current Allergy List:** ☐ Faxed with Referral

Request Appointment Date of: (yyyy/mm/dd) _____ **OR:** ☐ Today ☐ Tomorrow ☐ 1 Week ☐ 2 Weeks ☐ 1 Month

Priority: ☐ Routine ☐ Urgent **** Please page the pediatric cardiologist on call if requested appointment date is within 1 week ****

Previous Echo: ☐ Yes, at HHS ☐ Yes, outside HHS ☐ No ☐ Unknown

Anatomical Diagnosis:

☐ Normal ☐ Unknown ☐ Anomalous Pulmonary Venous Return ☐ Aortic Arch Abnormalities
☐ Aortopulmonary Window ☐ Atrioventricular Septal Defect ☐ Cardiomyopathy
☐ Common Arterial Trunk and Hemi-Truncus ☐ Cor Triatriatum ☐ Double Outlet Right Ventricle
☐ Dysplastic Aortic Valve ☐ Ebstein's / Tricuspid Dysplasia ☐ Hypoplastic Left Syndrome
☐ Isomerism ☐ LVOT Obstruction ☐ Mitral Valve Dysplasia / Prolapse ☐ Pulmonary Atresia
☐ Pulmonary Valve Dysplasia ☐ Tetralogy of Fallot ☐ Transposition of Great Arteries
☐ Tricuspid Atresia ☐ Tumour (Cardiac) ☐ Vascular Ring ☐ Ventricular Septal Defect
☐ Other (please specify) _____

Reason For Exam:

☐ Abnormal Cardiovascular Findings on Obstetrical Scan
☐ Abnormal Extra Cardiac Findings on Obstetrical Scan ☐ Arrhythmia
☐ Family History of Cardiomyopathy ☐ Family History of Congenital Heart Defect
☐ Fetal Exposure to Maternal Auto-Immune Antibodies ☐ Fetal Exposure to Teratogenic Medications
☐ Genetic Anomaly Suspected ☐ Maternal Infection ☐ Pre or Gestational Diabetes
☐ Rule out Pericardial Effusion ☐ Other (please specify) _____

Gestational age (weeks) _____ Expected due date (yyyy/mm/dd) _____

G – Gravida _____ L – Live _____ Multiple pregnancy: ☐ Yes ☐ No Monochorionic: ☐ Yes ☐ No

P – Para _____ A – Abortus _____ Number of fetus: _____ Monoamniotic: ☐ Yes ☐ No

Comments: _____

Please fax legibly completed form and accompanying documentation, including results of tests already completed, to **905-521-5056**. **Incomplete referrals <u>WILL NOT BE PROCESSED.</u>**

If you have any questions about your referral, please contact: (905) 521-2100 ext. 73974

Confirmation of Appointment Date and Time will be provided to the referring physician. It is the referring physician's responsibility to notify their patient of the details.