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FETAL CARDIOLOGY CONSULTATION / FETAL ECHOCARDIOGRAM REFERRAL

For pediatric referrals, please use the
Pediatric Cardiology Referral Form (712563) or the
Pediatric Echocardiogram Requisition (712663)

Patient's Last Name	First Name	
Address – Street	City	Postal Code
Telephone: ()	Ext.	
Cell Phone: ()		
Date of Birth (yyyy/mm/dd)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F
HIN	Family Physician	

Date: (yyyy/mm/dd) _____

Referring Physician _____

Physician's Signature _____

Phone: _____ (ext) _____

Fax: _____

OHIP Billing Number _____

Patient's M # _____

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 WILL NOT BE PROCESSED.**

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

Confirmation of Appointment Date and Time will be provided directly to the patient.

