McMaster Children's Hospital

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PEDIATRIC CARDIOLOGY CONSULTATION REFERRAL

***If you are referring for echo only, do not use this form. Please use the Pediatric Echocardiogram Referral form (712663), available: Internally: HHS Policy Library**

Externally: https://www.hamiltonhealthsciences.ca/mcmaster-childrens-hospital/areas-of care/medicine/cardiology-clinic/

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: ________________________________

OHIP Billing Number ____________________

Patient's M # ____________________________

☐ Interpreter required
→ Language _________________________

☐ CAS / FACS Involvement – (case manager & contact information)

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Parent or Guardian Name: ________________________________ **Email:** ________________________________

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

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Reason(s) for Referral (Please select all that apply)

Murmur: Grade ____/ 6 ☐ systolic ☐ diastolic

Palpitations: ☐ at rest ☐ with exertion

Chest pain: ☐ at rest ☐ with exertion

Syncope: ☐ at rest ☐ with exertion

Pre-syncope: ☐ at rest ☐ with exertion

SOB/dyspnea: ☐ at rest ☐ with exertion

☐ **Kawasak**i: Diagnosis Date ______________ (yyyy/mm/dd)

→ Treated with IVIG ☐ Yes ☐ No

If any of the 5 issues listed below apply, <u>details must be included with this referral</u>

☐ Abnormal ECG (strips must be faxed) ____________________

____

☐ Known cardiac disease *(specify)* ____________________

☐ Syndromes/Dysmorphisms *(specify)* ____________________

☐ Family History of congenital cardiac defects *(relationship and diagnosis)* ____________________

☐ Family History of sudden death *(relationship, age, cause)*

____

Details of Referral: (frequency of symptoms and other signs and symptoms) ____________________________________

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<u> Please page the pediatric cardiologist on call if the expected date of appointment is within 1 week **</u>**

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.