Ontario Health
CorHealth Ontario

Coronary Angiogram Referral Form
Kingston Health Sciences Centre

Fax:613-548-2407 Phone:613-548-1399-2

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston
Hôpital Hotel Dieu Hospital
KGH Hôpital Général de Kingston General Hospital

Instructions: Send to Regional Cardiac Centre directly. Do NOT send to CorHealth Ontario. Select only one option, unless noted otherwise.

Patient Information

First Name:	Middle Name:	Last Name:

Heath Card Number: Auth. Issuing:	DOB: YYYY-MM-DD	MRN:

Street Address:	Suite:	City:	Prov./State:

Postal/Zip Code:	Country: If outside Canada	Primary Phone:	Alternate Phone:

Language of Preference:

Referral Information

Referring Physician: Name and/or CPSO Number

Wait Location: Indicate Hospital name & location

If not from Hospital, select location: ***
☐ Home ☐ Rehabilitation Facility ☐ Medical Facility Outside of Province
☐ Medical Facility Outside of Country

Reasons for Referral:
Indicate P beside your selection to indicate Primary Reason for Referral, and S, if applicable, to indicate one Secondary Reason for Referral.

Coronary Disease:
__ Stable Angina (or Equivalent)
__ Unstable Angina (or Equivalent)
__ Non-ST-Segment Elevation Myocardial Infarction (NSTEMI)
__ ST-Segment Elevation Myocardial Infarction (STEMI)

Valve Disease:
__ Aortic Regurgitation
__ Aortic Stenosis
__ Other Valvular

Arrhythmia:
__ Atrial Flutter
__ Atypical Atrial Flutter
__ Atrioventricular Nodal Re-entrant Tachycardia (AVNRT)
__ Atrial Tachycardia
__ Paroxysmal Atrial Fibrillation
__ Persistent Atrial Fibrillation
__ Ventricular Fibrillation
__ Ventricular Tachycardia
__ Wolff-Parkinson-White Syndrome

__ **Cardiomyopathy**
__ **Congenital/Structural**
__ **Heart Failure**

Heart Transplant:
__ Donor
__ Recipient

Other:
__ Heart Disease of Other Etiology
__ Protocol (Research/Employment)
__ Syncope

Additional Notes:

Diagnostic Information

Canadian Cardiovascular Society Classification:
☐ 0 ☐ I ☐ II ☐ III ☐ IV

Acute Coronary Syndrome Classification:
☐ Low Risk ☐ Intermediate Risk
☐ High Risk ☐ Emergent

☐ Cardiogenic Shock

Exercise ECG Risk:
☐ Low Risk
☐ High Risk
☐ Uninterpretable
☐ Not Done

Rest ECG Ischemic Changes:
☐ Persistent (Fixed)
☐ Transient without Pain
☐ Transient with Pain
☐ Uninterpretable
☐ No

Functional Imaging Risk:
☐ Low Risk
☐ High Risk
☐ Uninterpretable
☐ Not Done

History of Myocardial Infarction:
☐ Recent (≤30 days) ☐ History (>30 days) ☐ No

History of Congestive Heart Failure:
☐ Yes ☐ No

History of CABG Surgery:
☐ Yes ☐ No

Serum Creatinine:
_____ µmol/L

Height:
_____ cm

Weight:
_____ kg

Referring Physician Signature:

Referral Date: YYYY-MM-DD