Hôpital St-Boniface Hospital

CARDIAC SCIENCES MANITOBA
SCIENCES CARDIAQUES MANITOBA

Manitoba Adult Congenital Heart Clinic Referral Form

Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Phone: Home: ( )_____Cell/Work: ( )_____
DOB: _____/_____/_____ Age: _____ years Sex: **M** **F**
Height: _____ cm Weight:_____ kg
MHSC#: _____ PHIN#: _____

Underlying congenital heart defect: _____

Previous corrective procedures/ surgeries (including date, where performed, and OR reports if available):

☐ Yes Details: _____
_____

☐ No

☐ Surgical history is unknown

If female and of childbearing age:

Is the patient pregnant: ☐ No ☐ Yes Due date: _____

Is the patient planning to become pregnant: ☐ No ☐ Yes ☐ Unknown

Recent Tests:

☐ Echo (enclose results or indicate date ordered) _____
☐ ECG (enclose results or indicate date ordered) _____
☐ CT (enclose results or indicate date ordered) _____
☐ MRI (enclose results or indicate date ordered) _____
☐ Other: _____

Is the Patient currently or recently hospitalized? ☐ No ☐ Yes

Please share relevant details including recent progress notes: _____
_____
_____

Does the patient have any cardiac implantable electronic devices? ☐ No ☐ Yes PPM ICD CRT-P CRT-D

Current medications:

Does the patient require a translator? ☐ No ☐ Yes

If yes - for what language? _____

Comments/ pertinent physical findings/ current clinic letter: _____
_____
_____

Fax completed referral to 204-233-2157

LEGEND: echo = echocardiogram
ECG= electrocardiogram
CT= computer tomography
MRI= magnetic resonance imaging
PPM= permanent pacemaker
ICD= implantable cardioverter defibrillator
CRT-P= cardiac resynchronization therapy pacemaker
CRT-D= cardiac resynchronization therapy defibrillator

Physician's Signature _____ MD

Printed Name _____ MD

Date of Referral: D D M M M Y Y Y Y

Date of Receipt: D D M M M Y Y Y Y

FOR CLINIC USE ONLY