

PCI Referral Form

Patient Name: _____
 Referring Dr: _____
 Cathing Dr: _____

Age: ____ Sex: ____
 Referral Date: ____
 Cathing Date: _____

Brief Clinical Summary

Patient Location
 Home / Hospital _____

:

Dye Allergy? _____ **Ischemic Testing:** _____
 Peripheral vascular disease ____ CVA _____ ECG +ve -ve
 Diabetes? ____ If yes, treatment: Diet ____ Oral Agents ____ Insulin ____ Thallium/Cardiolite +ve -ve
 IF patient in a study, which one? _____ Stress Echo +ve -ve

*?Coumadin? _____ last dose? _____ ASA? _____ Plavix? _____ Loaded? _____

Creatinine? _____ LVEF: _____ % CCS Angina Class 0 1 2 3 4 a b c

History of MI

Date of most recent MI: _____ Location: Ant Infer Lat
 ST Elevation MI? _____ Peak Troponin _____ Thrombolysis? ____ Drug: ____
 Non Q MI? _____ Post Infarct Angina? _____

Acceptance Date: _____

RVC PCI Date: _____ **RVC Interventionalist:** _____

PCI Referral to: SMH UHN SWCHSC Other: _____ **Medical Treatment** Y ____ N ____
Cardiac surgery referral: _____ Centre: _____

Comments:

REVIEWED BY:
 Vijayaraghavan
 Gladstone
 Kassam
 LI
 Burstein

: Date faxed _____ To: _____