VANCOUVER ISLAND health authority

Island Health Inherited Hypertrophic Cardiomyopathy Clinic
Dr. Olivier Desplantie, Western Cardiology
Ph: 250-595-1551 Fax: 250-595-6793

REFERRAL FOR:

☐ Cardiology only ☐ Cardiology assessment and genetic counselling (multidisciplinary)

PATIENT DEMOGRAPHICS:

NAME (LAST, FIRST):

ADDRESS:		TELEPHONE Home: Work: Cell:
CITY:	POSTAL CODE:	
D.O.B.: (YY/MM/DD)	HEALTH CARD #:	INTERPRETER NEEDED: ☐ Language:
ALTERNATE CONTACT NAME:		RELATIONSHIP:

REFERRING CLINICIAN:

NAME:	Specialty:	Billing number:
ADDRESS:		
TELEPHONE:		FAX:

POINT OF REFERRAL:

☐ Emergency ☐ Physician's Office ☐ Outpatient Clinic ☐ Inpatient (location):

☐ Other (specify): ☐ Unknown

URGENCY:

☐ Routine ☐ Semi-Urgent ☐ Urgent

REFERRAL CONDITION (check any that applies):

☐ Genetic evaluation
☐ Assistance with medical management
☐ Refractory to medical management (?surgical consideration)
☐ ICD consideration
☐ Positive Family History for HCM

☐ Positive Genetic Test Result: ____________________
☐ Other (details): ________________________________

FAMILY MEMBER(S) REFERRED: ☐ Yes Relationship: ☐ No ☐ Unknown

HCM SUBTYPE

☐ Obstructive ☐ Non-obstructive ☐ Apical-Variant

TESTS COMPLETED (please attach copies):

☐ ECG	☐ Stress Test	☐ Pyrophosphate scan
☐ Echocardiogram	☐ Holter Monitor	☐ Genetic Testing
☐ Cardiac MRI	☐ Biopsy	☐ Other:

GENETICS:

Family known to Genetics? ☐ Yes ☐ No ☐ Unknown | Location of patient (province, country):

OTHER PERTINENT INFORMATION:

____________________ ____________________ ____________________

REFERRING PHYSICIAN PHYSICIAN SIGNATURE DATE (YYYY/MM/DD)

FAMILY PHYSICIAN (please print): ____

PLEASE FAX ALL PERTINENT DISCHARGE SUMMARIES, BLOOD WORK, CARDIAC INVESTIGATIONS (ECG, STRESS TEST, ECHO, ETC,), ALONG WITH COMPLETED REFERRAL FORM TO 250-595-6793