UNITY HEALTH TORONTO

Caring hearts. Leading minds.

Cardiometabolic Clinic
St. Michael's Hospital
Donnelly Wing, 7th Floor
Phone 416-864-5968
Fax 416-864-5974

Patient Name:	Patient Label Here
DOB:	
OHIP#:	
Phone:	

Cardiometabolic/Prevention Clinic Referral Form

Referring Provider:		**Billing no:**	Patient's PCP:	
Date of Referral:			Referral Type:	□ New Referral □ Previously Seen
Phone Number:			Fax Number:	

Reason for Referral: □ 1) CV Risk Assessment, no prior known ASCVD (primary prevention)
□ 2) CV Risk Reduction, known ASCVD (secondary prevention)

Brief History:

Risk Factors:		**Past Cardiovascular History (if applicable):**	
Diabetes:	□ Yes □ Insulin Dependent	CAD:	□ Yes □ ACS □ PCI □ CABG □ Angina
Hypertension:	□ Yes	PAD:	□ Yes
Dyslipidemia:	□ Yes □ FH	Stroke:	□ Ischemic □ Hemorrhagic
OSA:	□ Yes □ On CPAP	HF:	□ HFrEF □ HFpEF □ EF:____%
CKD:	□ Yes □ Albuminuria	AF:	□ Yes
Obesity:	□ Yes **BMI:**_____	Other:	Describe: _____
Smoking:	□ Current □ Former		
Inflammatory Conditions:	□ Yes **Type:**	**Medication List Attached:**	□
Family History	□ Yes (Men < 55, Women < 65)	**Consult/Clinic Notes Attached:**	□
Other:	Describe: _____		

Biomarkers/Labs: *Please attach the following, if available within the last 6 months*

Troponin (*if done)*:	□ Yes	□ No	Lipid Panel:	□ Yes	□ No
HgA1c:	□ Yes	□ No	Lp(a) (*if ever done)*:	□ Yes	□ No
CBC, lytes, Cr	□ Yes	□ No	CRP:	□ Yes	□ No

Imaging/Tests: *Please attach the following, if available*

ECG (within last 6 months)	□ Yes	□ No	Carotid Ultrasound:	□ Yes	□ No
CT Coronary Angiogram:	□ Yes	□ No	Carotid IMT:	□ Yes	□ No
Coronary Catheterization:	□ Yes	□ No	Coronary Artery Calcium:	□ Yes	□ No
Stress Testing:	□ Yes	□ No	Echocardiogram:	□ Yes	□ No

Fax completed forms to: 416 864 5974