ST. MICHAEL'S
UNITY HEALTH TORONTO

CARDIAC SURGERY REFERRAL

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PATIENT INFORMATION

Patient Name:_____

DOB: _____

HCN:_____

Address: _____

_____

Contact Number: _____

PRIMARY CARDIOLOGIST

(if different from referring Doctor)

Name:_____

Contact Number: _____

REFERRING DOCTOR

Name: _____

Email: _____

Contact Number: _____

Fax Number: _____

COMMENTS: _____

_____

_____

_____

REASON FOR REFERRAL

Mitral Valve Disease

Aortic Aneurysm

Aortic Valve Disease

Minimally Invasive / Robotic

Coronary Artery Disease

Other: _____

_____

Please check off all tests that have been completed and fax results along with this referral page:

Note: If any imaging is on CD please send a copy to the address listed above.

Angiogram

Transthoracic Echo (TTE)

Transesophageal Echo (TEE)

CT

Chest X-Ray

MRI

Pulmonary Function Test

Bloodwork

Please send most recent consult notes.