

**CARDIOLOGY REFERRAL: SASKATOON**

<b>PATIENT INFORMATION:</b>		Last Name:	First Name:
Date of Birth: DD/MMM/YYYY	Address:		
City:	Prov:	PC:	HSN:
Home Phone:	Work Phone:	Cell Phone:	
E-Mail:	Gender <input type="checkbox"/> M <input type="checkbox"/> F		
<b>REFERRING PRACTITIONER &amp; CLINIC INFORMATION:</b>			
<input type="checkbox"/> Family Doctor	Name: _____		
<input type="checkbox"/> Nurse Practitioner	Address: _____		
<input type="checkbox"/> Specialist	Phone: _____		
<input type="checkbox"/> Other (Specify) _____	Fax: _____		
<b>REFERRAL TO:</b>			
<input type="checkbox"/> Next Available Cardiologist Except Dr. _____		<input type="checkbox"/> Urgent (Explain): _____	
<input type="checkbox"/> Specific Dr. _____			
<b>REASON FOR REFERRAL:</b> CHECK REASON AND INCLUDE REFERRAL LETTER, RELEVANT PREVIOUS DOCUMENTATION - DIAGNOSTIC LABS OR IMAGING, ECG (IF AVAILABLE), CONSULTS, INTERVENTIONS, PREVIOUS CARDIAC INVESTIGATIONS, AND SURGICAL REPORTS.			
<input type="checkbox"/> None Available			
<b>PLEASE NOTE THAT ANY FURTHER INVESTIGATIONS WILL BE ARRANGED BY THE RECEIVING CARDIOLOGIST.</b>			
<b>Chest Pain</b>	<input type="checkbox"/> Stress Test Only <input type="checkbox"/> Chest Pain Consult <input type="checkbox"/> Known Coronary Disease Assessment		
<b>Arrhythmia</b>	<input type="checkbox"/> Palpitations Not Yet Determined <input type="checkbox"/> Syncope <input type="checkbox"/> Known Arrhythmia: _____ <input type="checkbox"/> Cardio Electrophysiology Assessment (Catheter Ablation/ICD Assessment) Describe: _____		
<b>Congestive Heart Failure</b>	<input type="checkbox"/> Dyspnea <input type="checkbox"/> Known Congestive Heart Failure: _____		
<b>Murmur/Valvular Disease</b>	<input type="checkbox"/> Known Valvular Disease: _____ <input type="checkbox"/> New Murmur		
<b>Congenital Heart Disease</b>	<input type="checkbox"/> Specify Diagnosis: _____		
<b>Aortic Disease</b>	<input type="checkbox"/> Specify Diagnosis: _____		
<b>Other</b>	<input type="checkbox"/> Please Describe: _____		
<b>NOTES:</b>			
<p><b>POOLED REFERRAL INFORMATION:</b> Patients offered the pooled referral option will receive the next available appointment with a specialist able to treat the referring condition. Specialists who choose to pool their referrals but do not share an office may use the Referral Management Service at eHealth Saskatchewan to manage the intake of patient referrals. This service shares de-identified referral information with all the specialists in this group to aid in reducing patient wait times and improving the patient experience.</p>			
Physician Signature:			Date:
<b>Redirecting Specialist:</b>			Date:
<input type="checkbox"/> Pooled <input type="checkbox"/> Specific Dr. _____			