PACIFIC ADULT CONGENITAL HEART CLINIC REFERRAL

Providence HEALTH CARE
How you want to be treated.

DATE: _____

REFERRAL TO (please indicate clinic)**:**

- ☐ Adult Congenital Heart Clinic (PACH)
- ☐ Cardiac Obstetric Clinic (COB)
- ☐ Heritable Aortopathies Clinic (HAC)

***For urgent requests, please call the PACH physician on call (604 682 2344)*

PATIENT NAME: _____ Gender: ☐ Male ☐ Female

Maiden name/previous name: _____ PHN #: _____

Date of Birth: (dd/mmm/yyyy) _____

Address: _____

Language spoken (if not English): _____ Interpreter required? ☐ no ☐ yes

Phone: Home: _____ Alternate contact:

Work: _____ Name: _____

Cell: _____ Phone Number: _____

DIAGNOSIS or SUSPECTED DIAGNOSIS: _____

REASON FOR REFERRAL: _____

ALLERGIES: _____ **LAST MENSTRUAL PERIOD** (if pregnant): _____

MEDICATIONS: _____

Adult Congenital Clinics occur every Tuesday and Thursday afternoon, Cardiac Obstetrics every Monday afternoon, and Heritable Aortopathy Clinic is on Tuesday mornings (twice a month)

Service requested:
- ☐ Consultation only
- ☐ Cooperative care
- ☐ Assume care & management

Request patient to be seen:
- ☐ urgent (1 week)
- ☐ routine (6 weeks)
- ☐ semi urgent (4 weeks)
- ☐ within _____ months

REFERRING Physician: MSP No. _____

Name: _____

Phone: _____

Fax: _____

Address: _____

_____

Signature: _____

FAMILY Physician: MSP No. _____

Name: _____

Phone: _____

Fax: _____

Address: _____

_____

Antenatal care provided by: _____

ACCOMPANYING MATERIALS Receipt of the additional clinical information will expedite appointment booking.

Attached		N/A
☐	Referral letter	
☐	Past records relating to congenital heart condition	
☐	All cardiac surgery operative reports	
☐	ECG report (most recent)	
☐	Holter Monitor report	
☐	Echocardiogram report (most recent)	
☐	Chest x-ray report	
☐	Blood work results (most recent)	

Attached		N/A
☐	Exercise stress test report (most recent)	
☐	Holter monitor report (most recent)	
☐	Cardiac nuclear medicine reports	
☐	All cardiac catheterization reports	
☐	All MRI/CT scan reports	
☐	Obstetrical ultrasound	
☐	Fetal Echocardiogram report	
☐	Antenatal records	

PLEASE MAIL, COURIER OR FAX INFORMATION TO:

Pacific Adult Congenital Heart (PACH) Clinic
St. Paul's Hospital
Room 5051, 1081 Burrard Street
Vancouver, BC V6Z 1Y6

PHONE: 604-806-8520
FAX: 604-806-8800
EMAIL: pach@providencehealth.bc.ca

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