London Health Sciences Centre

Referral to:

Hypertrophic Cardiomyopathy Program

LHSC -University Hospital
339 Windermere Road, London, ON, N6A 5A5
Telephone: 519-663-3032 **Fax:** 519-663-3114

PATIENT NAME:	LHSC PIN # (if known):	☐ INPATIENT ☐ OUTPATIENT
ADDRESS:	Phone: Email:	
CITY:	POSTAL CODE:	
D.O.B.: (YY/MM/DD)	HIN #:	Version Code:

REFERRING CLINICIAN INFO:

NAME:	
ADDRESS:	
TELEPHONE:	**FAX:**

REASON FOR REFERRAL:

☐ Hypertrophic Cardiomyopathy ☐ Query HCM ☐ Genetic Testing ☐ Screening (Family Hx of HCM)

☐ Other (specify):

TESTS PERFORMED (Please Fax Reports):

☐ Echocardiogram	☐ Stress Test
☐ Cardiac MRI	☐ Holter Monitor
☐ Genetic Testing	☐ Bloodwork
☐ MIBI	☐ ECG

PRIOR PROCEDURES:

☐ Cardiac Catheterization ☐ Cardiac Surgery ☐ Prior Defibillator

OTHER PERTINENT INFORMATION:

Have any family members been seen in this clinic or by genetics?

☐ Yes (Name and relationship: ______________________________) ☐ No ☐ Unknown

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

PLEASE FAX ALL PERTINENT DISCHARGE SUMMARIES, BLOOD WORK, CARDIAC INVESTIGATIONS (ECG, STRESS TEST, ECHO, ETC,), ALONG WITH COMPLETED REFERRAL FORM TO 519-663-3114.

PLEASE VISIT OUR WEBSITE FOR MORE INFORMATION:

https://hcm-clinic-forward.vercel.app/