PRINT

London Health Sciences Centre

Referral to:

Hypertrophic Cardiomyopathy Clinic

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:	TEL: ALT TEL: Email:	
CITY:	POSTAL CODE:	
D.O.B.: (YY/MM/DD)	HIN #:	Version Code:

REFERRING CLINICIAN:

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://www.lhsc.on.ca/cardiac-care-services/hypertrophic-cardiomyopathy-clinic