



**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):	<input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT
ADDRESS:		TEL:	ALT TEL:
		Email:	
CITY:		POSTAL CODE:	
D.O.B.: (YY/MM/DD)		HIN #:	Version Code:
Dr. McCarty Dr. Thain Dr. Ward 1st Available			
REFERRING CLINICIAN:			
NAME:			
ADDRESS:			
TELEPHONE:		FAX:	
REASON FOR REFERRAL:			
<input type="checkbox"/> Hypertrophic Cardiomyopathy <input type="checkbox"/> Query HCM <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Screening (Family Hx of HCM)			
<input type="checkbox"/> Other (specify):			
TESTS PERFORMED (Please Fax Reports):			
<input type="checkbox"/> Echocardiogram		<input type="checkbox"/> Stress Test	
<input type="checkbox"/> Cardiac MRI		<input type="checkbox"/> Holter Monitor	
<input type="checkbox"/> Genetic Testing		<input type="checkbox"/> Bloodwork	
<input type="checkbox"/> MIBI		<input type="checkbox"/> ECG	
PRIOR PROCEDURES:			
<input type="checkbox"/> Cardiac Catheterization		<input type="checkbox"/> Cardiac Surgery	
<input type="checkbox"/> Prior Defibrillator			
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>