ALL NEW PATIENTS REQUIRE PHYSICIAN REFERRAL.
ALL REFERRALS ARE TRIAGED.
IF THIS IS AN URGENT REFERRAL PLEASE CALL 613.737.7600 AND PAGE THE CARDIOLOGIST ON CALL.

DEPARTMENTAL USE ONLY

Date Received: d_____m_____y_____

CARDIOLOGY CLINIC REFERRAL FORM

Mail to: Children's Hospital of Eastern Ontario
Division of Cardiology
401 Smyth Rd
Ottawa, ON
K1H 8L1

Phone: 613-737-7600 ext 3091
Fax: 613.738.4835

PATIENT INFORMATION *(Please print):*	**PHYSICIAN INFORMATION *(Please print):***
Patient Name:	Referring Physician:
Date of Birth: (d) /(m) /(y)	HCP#:
Address:	Physician Address:
Phone:	Phone (Direct Line):
Work Phone:	FAX Number:
Health Insurance Number:	
Language: ☐ English ☐ French ☐ Bilingual ☐ Other Is an interpreter required? ☐ NO ☐ YES: _____	**Signature:**

Medical Information and Reason for Referral
Please provide copies of any relevant test results

Relevant family history:

OTHER INFORMATION:

Has the child been previously assessed in Cardiology? ☐ NO ☐ YES

Is the patient followed by or referred to another Pediatric Subspecialist? ☐ NO ☐ YES: _____

Is the patient/family aware that you have requested this consultation? ☐ NO ☐ YES

PLEASE NOTE:

- The patient will be notified directly with their appointment time.
- If the status of the patient changes, please re-send the referral, indicating the change in status.
- Please instruct patients to contact the clinic should their appointment no longer be required.
- **IMPORTANT:** The **referring physician remains responsible** for the care of the patient prior to the Pediatric Cardiology consultation at CHEO.

REVISED: February 2010