

Cardiometabolic Clinic
 St. Michael's Hospital
 Donnelly Wing, 7th Floor
 Phone 416-864-5627
 Fax 416-864-6065

Patient Name:	Patient Label Here
DOB:	
OHIP#:	
Phone:	

Cardiometabolic/Prevention Clinic Referral Form

Referring Provider:	Billing no:	Patient's PCP:
Date of Referral:	Referral Type:	<input type="checkbox"/> New Referral <input type="checkbox"/> Previously Seen
Phone Number:	Fax Number:	

Reason for Referral: 1) CV Risk Assessment, no prior known ASCVD (primary prevention)
 2) CV Risk Reduction, known ASCVD (secondary prevention)

Brief History:

Risk Factors: Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> Insulin Dependent Hypertension: <input type="checkbox"/> Yes Dyslipidemia: <input type="checkbox"/> Yes <input type="checkbox"/> FH OSA: <input type="checkbox"/> Yes <input type="checkbox"/> On CPAP CKD: <input type="checkbox"/> Yes <input type="checkbox"/> Albuminuria Obesity: <input type="checkbox"/> Yes BMI: _____ Smoking: <input type="checkbox"/> Current <input type="checkbox"/> Former Inflammatory Conditions: <input type="checkbox"/> Yes Type: _____ Family History: <input type="checkbox"/> Yes (Men < 55, Women < 65) Other: Describe: _____	Past Cardiovascular History (if applicable): CAD: <input type="checkbox"/> Yes <input type="checkbox"/> ACS <input type="checkbox"/> PCI <input type="checkbox"/> CABG <input type="checkbox"/> Angina PAD: <input type="checkbox"/> Yes Stroke: <input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic HF: <input type="checkbox"/> HFrEF <input type="checkbox"/> HFpEF <input type="checkbox"/> EF: _____% AF: <input type="checkbox"/> Yes Other: Describe: _____
	Medication List Attached: <input type="checkbox"/> Consult/Clinic Notes Attached: <input type="checkbox"/>

Biomarkers/Labs: *Please attach the following, if available within the last 6 months*

Troponin (if done): <input type="checkbox"/> Yes <input type="checkbox"/> No	Lipid Panel: <input type="checkbox"/> Yes <input type="checkbox"/> No
HgA1c: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lp(a) (if ever done): <input type="checkbox"/> Yes <input type="checkbox"/> No
CBC, lytes, Cr <input type="checkbox"/> Yes <input type="checkbox"/> No	CRP: <input type="checkbox"/> Yes <input type="checkbox"/> No

Imaging/Tests: *Please attach the following, if available*

ECG (within last 6 months) <input type="checkbox"/> Yes <input type="checkbox"/> No	Carotid Ultrasound: <input type="checkbox"/> Yes <input type="checkbox"/> No
CT Coronary Angiogram: <input type="checkbox"/> Yes <input type="checkbox"/> No	Carotid IMT: <input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Catheterization: <input type="checkbox"/> Yes <input type="checkbox"/> No	Coronary Artery Calcium: <input type="checkbox"/> Yes <input type="checkbox"/> No
Stress Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Echocardiogram: <input type="checkbox"/> Yes <input type="checkbox"/> No

Fax completed forms to: 416 864 6065