HYPERTROPHIC CARDIOMYOPATHY CLINIC

St. Paul's Hospital
B480-1081 Burrard Street   Vancouver, BC   V6Z 1Y6
Phone: 604-682-2344 ext: 63284   Fax: 604-602-8658

PATIENT NAME:	☐ MALE ☐ FEMALE ☐ ________
ADDRESS:	TEL# (HOME/CELL):
CITY:	POSTAL CODE:
DOB (DD/MM/YYYY):	PHN:

REFERRING PHYSICIAN:

NAME:	OFFICE #:	FAX #:
ADDRESS:		

REASON FOR REFERRAL:

☐ Hypertrophic Cardiomyopathy ☐ Query HCM ☐ Other (provide details):

☐ Screening (family history of HCM) ☐ Genetic Testing

PRIOR TESTS (please fax reports)

☐ Echocardiogram ☐ Stress Test ☐ Bloodwork

☐ Cardiac MRI ☐ Holter monitor ☐ Genetic Testing

PRIOR PROCEDURES (please fax reports)

☐ Cardiac catheterization ☐ Cardiac surgery ☐ Prior Defibrillator

REFERRAL INFORMATION:

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

☐ Yes (name and relationship: ________________________________) ☐ No ☐ I don't know

☐ Urgent referral (will be reviewed and triaged) ☐ Next available appointment

REFERRING PHYSICIAN (MSP #) ______________   PHYSICIAN SIGNATURE ______________   DATE (DD/MM/YYYY) ______________

IMPORTANT: PLEASE FAX CLINICAL NOTES, BLOODWORK, AND OTHER RELEVANT INFORMATION WITH COMPLETED REFERRAL FORM TO 604-602-8658.