HYPERTROPHIC CARDIOMYOPATHY CLINIC
Mailing Address: 518 – 1033 Davie Street, V6E 1M7
Phone: 604-682-2344 ext: 66772 Fax: 604-806-8097

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 / Pacemaker

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	PHYSICIAN SIGNATURE	DATE (DD/MM/YYYY)

IMPORTANT: PLEASE FAX CLINICAL NOTES, BLOODWORK, AND OTHER RELEVANT INFORMATION WITH COMPLETED REFERRAL FORM TO 604-806-8097.