BC CHILDREN'S HOSPITAL
An Agency of the Provincial Health Services Authority

CHILDREN'S HEART CENTRE
HEART FUNCTION PROGRAM REFERRAL

NAME: _____
PHN: _____
MRN: _____ Male ◯ Female ◯
DOB: _____
ADDRESS: _____
PHONE #: _____
PARENTS NAMES: _____

REFERRING SERVICE-PLEASE COMPLETE THIS SECTION:

TODAY'S DATE:

REQUESTING PHYSICIAN (Please Print):

BILLING #:

REFERRING SERVICE:

CONTACT NUMBER-Physician:

REASON FOR REQUEST:

- ☐ Congenital heart disease with decreased cardiac function or symptoms of heart failure
- ☐ Cardiomyopathy with decreased cardiac function or symptoms of heart failure
- ☐ Oncology patient with decreased cardiac function

CARDIOMYOPATHY SCREENING:

- ☐ Family history of cardiomyopathy → If family history of CMD include
  - ☐ Pedigree
  - ☐ Genetics
  - ☐ Consult notes of affected 1° relatives
- ☐ Neuromuscular conditions
- ☐ Metabolic conditions
- ☐ Genetic conditions

OTHER:

- ☐ Systemic disease or other organ failure [ie chronic kidney disease]
- ☐ Fontan patients at 5 years post-operatively

HISTORY:

MEDICATIONS:

_____
_____
_____

LAST BNP: _____

PACEMAKER: YES ◯ NO ◯

INTERPRETER REQ'D: YES ☐ NO ☐

Please fax all referrals to 604-875-3463

HEART CENTRE USE ONLY

TRIAGED BY:

TO BE SEEN IN:

OUTPATIENT Height (cm):

OUTPATIENT Weight (kg):

APPOINTMENT DATE & TIME:

NOTES:

TESTING REQUIRED:

☐ CONSULT	☐ EXERCISE TEST	☐ CXR
☐ ECHO	☐ 24 HOUR HOLTER	☐ OTHER _____
☐ ECG	☐ BLOODWORK	☐ OTHER _____