UNIVERSITY OF OTTAWA
HEART INSTITUTE
INSTITUT DE CARDIOLOGIE
DE L'UNIVERSITÉ D'OTTAWA

CENTRE OF VALVULAR HEART DISEASE (CVHD) REFERRAL FORM

Tel: 613-696-7403
Fax: 613-696-7109
Email: CVHD@ottawaheart.ca

PATIENT NAME:	**OHIP:** **VC:** **Other:** **Exp:**
Sex: ☐ Female ☐ Male ☐ Other	**Language: ☐ English ☐ French ☐ Other**
Date of Birth: _ _ /_ _ _/ _ _ _ _ **D M Y**	
Address:	**Telephone (preferred number):**
City:	Home:
Prov:	Business:
Postal Code:	Cell:
Other contact:	Email:
URGENCY:	**REASON FOR REFERRAL:**
☐ Routine	☐ Mitral regurgitation
☐ Urgent: (1-2 weeks)	☐ Mitral stenosis
	☐ Aortic stenosis
TYPE OF REFERRAL	☐ Aortic regurgitation
☐ Evaluation and follow-up	☐ Tricuspid valve disease
☐ Second opinion	☐ Prosthetic valve: ☐ Mechanical ☐ Bioprosthetic
	☐ Disease of the aorta
	☐ Endocarditis
Notes:	☐ Murmur
	☐ Other
	If previous cardiac surgery :
	☐ Date:
	☐ UOHI

Please include the most recent information with your referral if available:

- **Blood work**
- **Cardiac Imaging reports**
- **Pertinent medical records including cardiac operative reports, previous cardiology consultations.**
- **Latest medication list**

Please note that the CVHD office will arrange diagnostic testing prior to consultation.

Referring Physician (Please Print)	**OHIP Billing Number:**	**Signature**	**Date:**
Address:		**Tel:**	**Fax:**