HOSPITAL STAMP HERE

Referral to Cardiac Supportive and Palliative Care Program

Date of Request: Referral From:

Phone: Fax:

Primary Care Provider: Phone:

Address: Fax:

Pharmacy Name: Phone:

Patient Name: DOB (yy/mm/dd):

Address: City:

Health Card Number: Postal Code:

Telephone: MRN:

Brief history and reason for referral:

Is patient/SDM aware of the referral? YES NO

Please include the following information with your faxed referral, if available:

- Patient's relevant past medical history
- List of current medications
- Recent bloodwork
- Any other relevant test results (e.g.: Chest X-ray, CT scan, VQ scan)

Please fax completed referrals to: 613-696-7138

Email: supportivecare@ottawaheart.ca
Telephone: 613-696-7000 ext. 14188