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

Referral Form

Cardiac Amyloidosis Clinic

Outpatient Referral to be faxed to 613-696-7138
Telephone: 613-696-7000 ext. 17000
40 Ruskin Street, Ottawa ON K1Y 4W7

Name _____
SURNAME *FIRST NAME* *INITIAL*

☐ Male ☐ Female ☐ Other DOB____/____/_____

Health Card Number: _____

Address _____

Postal Code_____Phone _____

REFERRAL URGENCY
☐ < 2 weeks ☐ < 1 month ☐ < 3 months ☐ < 6 months

Referring MD: _____

Referral Date: _____

Race (self-identified by the patient):
☐ Unknown ☐ Prefer Not to Answer ☐ Not Collected
☐ Black ☐ Middle Eastern ☐ East/Southeast Asian ☐ South Asian
☐ Indigenous ☐ White ☐ Latino ☐ Other:_____

TO BE COMPLETED BY REFERRING PHYSICIAN

AMYLOIDOSIS DIAGNOSIS:

☐ **SUSPECTED CARDIAC AMYLOID based on** (referrals will only be accepted if one or more of the following is selected)
- ☐ Cardiac MRI
- ☐ Pyrophosphate scan
- ☐ Transthyretin gene mutation

☐ **CONFIRMED CARDIAC AMYLOID based on**
- ☐ SPEP, UPEP, serum free light chains
- ☐ Pyrophosphate scan
- ☐ Endomyocardial biopsy
- ☐ Bone marrow biopsy
- ☐ Salivary lip gland biopsy
- ☐ Fat pad biopsy
- ☐ Other tissue biopsy: _____

Abnormal SPEP, UPEP or serum light chain ratio or confirmed AL Amyloidosis require urgent Hematology referral.

BRIEF HISTORY AND REASON FOR REFERRAL:

CLINICAL FINDINGS SUGGESTIVE OF AMYLOID
- ☐ Carpal tunnel syndrome
- ☐ Peripheral neuropathy
- ☐ Autonomic dysfunction
- ☐ Heart failure with preserved ejection fraction with lack of usual risk factors
- ☐ Chronic kidney disease
- ☐ Low voltage ECG despite LVH on imaging
- ☐ ECHO shows unexplained ventricular hypertrophy
- ☐ Arrhythmia (specify): _____
- ☐ Other: _____

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR FAX REFERRAL:

MANDATORY
- ☐ Consult letter/Recent clinic note
- ☐ List of current medications
- ☐ Relevant past medical history
- ☐ Echocardiogram (with strain imaging)
- ☐ Electrocardiogram
- ☐ CBC, electrolytes, creatinine, liver function tests
- ☐ NT Pro BNP/ BNP, troponin
- ☐ SPEP, UPEP
- ☐ Serum free light chains

OPTIONAL
- ☐ Cardiac MRI
- ☐ Pyrophosphate scan
- ☐ Genetic testing results
- ☐ Holter
- ☐ Stress test
- ☐ Coronary angiogram
- ☐ Biopsy (specify): _____
- ☐ Other (specify): _____

Referring Physician signature: _____ **Date (yyyy/mm/dd):** _____