The Ottawa Hospital | L'Hôpital d'Ottawa

Inspired by research. **Driven** by compassion. **Inspiré** par la recherche. **Guidé** par la compassion.

Department *of* Medicine
DIVISION OF CARDIOLOGY

Département *de* médecine
DIVISION DE CARDIOLOGIE

CARDIO-OBSTETRICS CLINIC

Referral Form

The Ottawa Hospital General Campus
501 Smyth Road, Ottawa, ON K1H 8L6
Phone: 613-737-8582 | Fax: 613-739-6727
Email: cardiologygen@toh.ca

Program Description

The **Cardio-Obstetrics Clinic** is a specialized cardiology clinic for women with: (1) established heart disease pre-pregnancy, during pregnancy, delivery, and post-partum (2) pregnant women with symptoms of heart disease or (3) women with previous cardiac complications of pregnancy. We are closely linked to the University of Ottawa Heart Institute (UOHI) Women's Heart Health Centre, UOHI CardioPrevent Post-Partum Rehabilitation Program and the UOHI Adult Congenital Heart Disease Clinic. We collaborate with obstetricians, maternal fetal medicine physicians, anesthesiologists, neonatologists, internal medicine specialists, endocrinologists, medical geneticists and cardiac rehabilitation.

Consultations in this clinic require referral from a physician or nurse practitioner. Referrals are quickly triaged according to urgency of symptoms, diagnosis, and expected date of delivery. Please complete the form in its entirety. Incomplete forms will be returned. Please include all relevant medical reports, labs, consult notes, and/or cardiac test results.

Please note: patients known to the UOHI Adult Congenital Heart Disease clinic or those with complex congenital heart disease (e.g. Tetralogy of Fallot, Fontan, Eisenmenger's, cyanotic congenital heart disease etc.) should be referred there first.

Patient Demographics

Surname:	First name:	DOB (yyyy/mm/dd)	Health Card No. & Version Code:
Address:	City:	Province:	Postal Code:
Telephone:	Alternate Phone:	Sex:	Preferred Language:

Clinical Information *(*fields are mandatory)*

Reason for Referral:*

Maternal age*___________ Gest age* _____________

G____ T____ P____ A____ L____ status*

Last Menstrual Period* (yyyy-mm-dd):_____________

Expected due date*(yyyy-mm-dd): _________________

Previous pregnancy complications (if applicable):

- ☐ Preeclampsia/eclampsia
- ☐ Gestational hypertension
- ☐ Gestational diabetes
- ☐ Other (please specify):

Cardiac History* (check if applicable)

- ☐ Peripartum cardiomyopathy
- ☐ Other cardiomyopathy / heart failure
- ☐ Non-complex congenital heart disease (ASD, VSD, etc.)
- ☐ Native valve dysfunction (BAV, rheumatic etc.)
- ☐ Mechanical valve(s) ____________________
- ☐ Bioprosthetic valve(s) ___________________
- ☐ Arrhythmias (SVT, AF/flutter, VT, bradyarrhythmias)
- ☐ Cardiac devices (pacemaker, ICD, CRT)
- ☐ Cardiac chest pain / previous coronary syndrome
- ☐ Pericardial disease
- ☐ Pre-pregnancy counselling in cardiac patients
- ☐ IVF / assisted reproduction in cardiac patients
- ☐ Other (please specify): ________________________

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Referring Physician / Practitioner

FULL NAME (print):	COLLEGE NO / BILLING NO:	SIGNATURE:
FULL ADDRESS (HOSPITAL/OFFICE NAME, STREET, CITY, PROVINCE, POSTAL CODE):		
TELEPHONE	FAX:	Requested Urgency: ☐ < 4 weeks ☐ 1-2 months ☐ > 2 months

Please remember to include all relevant medical reports, labs, consultation notes, and cardiac diagnostic testing reports.