911 Queen's Blvd
Kitchener, ONT N2M 1B2

Health Record # Insert patient label
OHIP #: ______________________________
Patient Name: ______________________________
DOB: ____/____/_____ Age: ☐ Female ☐ Male
Account: ____________________ Date of Admission: ___/___ /___

Structural Heart: PFO/ASD Referral Form

Please fax to 519-749-6414
Structural Heart Coordinator 519-749-6578 x1992

To request a Consultation for Minimally Invasive PFO or ASD closure at SMGH, please fax this form,
along with the information noted below, to 519-749-6414

Patient Name: PRINT (first, last)	
Patient Address:	
Patient Preferred Phone Number:	Patient Alternate Phone Number:
Primary Care Physician Name: (if different from referring physician)	
Primary Physician Contact Number:	

Indications: PFO or ASD plus (check all that apply):

☐ Cryptogenic stroke/Paradoxical embolism

☐ Unexplained hypoxia felt due to shunting

☐ Decompression illness

☐ Symptoms felt attributable to significant left to right shunt, absence of severe pulmonary hypertension

☐ Right sided chamber enlargement

☐ Large shunt by invasive/non invasive imaging

☐ Other: ____

PLEASE INCLUDE THE FOLLOWING REPORTS:

- Recent consult note
- Echocardiogram/Bubble study report
- Medication list
- Recent blood work
- Copies of neuro imaging (CT/MRI)

BY SIGNING THIS FORM, I confirm that this patient is aware of this referral.

Referring Physician Name: (PRINT)	Billing#:
Referring Physician Signature	Date: ______ /______ / ______
Phone Number:	Fax Number:

Questions regarding this referral can be directed to:

Rebecca Gies RN
Regional Cardiac Care Coordinator
Structural Heart Program
Phone: 519-749-6578 x1992
Fax: 519-749-6414
Email: rgies@smgh.ca

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