Trillium Health Partners

CARDIOGENETICS PROGRAM REFERRAL FORM

2200 Eglinton Ave W, Mississauga, ON L5M 2N1
Phone Number: 905-813-4104 Fax Number: 905-813-4347

Please note that a referral to this program may be declined if this form is incomplete and/or supporting documentation is not provided.

REFERRING HEALTH CARE PROVIDER

Name: _____ Billing Number: _____

Address: _____

Phone Number: _____ Fax Number: _____

REFERRAL REASON

☐ *Long QT Syndrome*
Greatest QTc interval (must be greater than or equal to 460 ms) _____ ms
Exercise Stress Test: ☐ Yes ☐ No
Provocative Drug Challenge: ☐ Positive ☐ Negative ☐ Pending

☐ *Hypertrophic Cardiomyopathy:*
Cardiac Septal Diameter (must be greater than or equal to 11 mm) _____ mm
☐ Symmetric ☐ Basal ☐ Reverse Curve

☐ *Brugada Syndrome:*
EKG Showing "Type 1" Brugada Pattern: ☐ Yes ☐ No
Provocative Drug Challenge: ☐ Positive ☐ Negative ☐ Pending

☐ *CPVT:*
Provocative Drug Challenge: ☐ Positive ☐ Negative ☐ Pending

☐ *Dilated Cardiomyopathy:*
Dilated Ventricle ☐ Left ☐ Right ☐ Both
Ejection Fraction _____ %

☐ *Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC):*
List findings on EKG and cardiac imaging studies supporting diagnosis **

** Criteria should be based on most recent Task Force Criteria presented in European HeartJournal (2010) 31, 806-814 Marcus, F.I. et al

☐ Disease specific criteria not met but clinical suspicion for: _____

Details:

☐ Family history of clinically diagnosed known cardiac condition

Specify:

☐ Family history of sudden cardiac death suggestive of an inherited cardiac condition

Details:

☐ Genetic mutation identified in family member (include copy of genetic result if available).

*Adapted from the Consensus statement from the Heart Rhythm Society/European Heart Rhythm Association (HRS/EHRA Consensus Statement on the State of Genetic Testing for the Channelopathies and Cardiomyopathies; Heart Rhythm, Vol 8, No 8, August 2011)

Please fax this completed form to Clinical Genetics at 905-813-4347

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