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HERITABLE AORTOPATHIES CLINIC REFERRAL

* 1 0 4 9 6 *

Cardiology Referral

Referral date: _____ ****For urgent requests, contact the VPACH physician on call (604-682-2344)**

PATIENT INFORMATION		
Name: (last, first)		**Telephone:**
Former name/maiden name:		Home: _____
Address:		Work: _____
City:	Postal Code:	Cell: _____
DOB: (dd/mmm/yyyy)	PHN:	☐ Interpreter required
Alternative contact: (name)		Language: _____
Relationship to patient:	Telephone:	

REFERRING CLINICIAN:		
Name:	Specialty:	Billing number:
Address:		
Telephone:	Fax:	

LEVEL OF URGENCY:

☐ Priority (within 6 weeks) Priority reason: _____
☐ Routine (within 3 months)

Patient pregnant? ☐ Yes ☐ No
**referral will be redirected to COB Clinic

REASON FOR REFERRAL:

☐ Syndromic aortopathy
- ☐ Marfan Syndrome
- ☐ Loeys Dietz Syndrome
- ☐ Ehlers Danlos Syndrome (Vascular Type 4)

☐ Nonsyndromic aortopathy (aortic aneurysm/dissection under age 60 in the absence of hypertension)

☐ Biopsy appearance of aortic connective tissue abnormality

Following confirmed genetic screening:

☐ First degree relative with syndromic aortopathy or aortic aneurysm/dissection, under age 60, plus documented aortic dilation

Previous genetic testing: ☐ No ☐ Yes – Result: (include report) _____

☐ Other: (details) _____

DIAGNOSIS:

☐ Confirmed ☐ Suspected ☐ Family History

FAMILY MEMBER(S) REFERRED:

☐ No ☐ Yes Relationship: _____
☐ Unknown

TESTS COMPLETED: (please attach copies)

☐ MRI ☐ ECG ☐ Holter Monitor ☐ Genetic Testing: (provide details) _____
☐ CT Scan ☐ Echocardiogram

GENETICS:

Family known to Genetics? ☐ Yes ☐ No ☐ Unknown Location seen: (province, country)

OTHER RELEVANT INFORMATION:

MEDICATIONS: _____

OTHER: _____

PLEASE FAX INFORMATION TO: **Heritable Aortopathy (HA) Clinic Fax: 604-602-8644**
St. Paul's Hospital, Room. 5051-1081 Burrard St. Vancouver, BC V6Z 1Y6
Telephone: 604-806-8520 Ext. 6 Email: SPHHAC@providencehealth.bc.ca