FAX PATIENT REFERRAL TO:
REFERRAL MANAGEMENT SERVICES
FAX: 1-855-355-1921
PHONE: 1-833-337-7770

CARDIOLOGY REFERRAL: SASKATOON

PATIENT INFORMATION:	Last Name:		First Name:
Date of Birth: DD/MMM/YYYY	Address:		
City:	Prov:	PC:	HSN:
Home Phone:	Work Phone:		Cell Phone:
E-Mail:	Gender ☐ M ☐ F		

REFERRING PRACTITIONER & CLINIC INFORMATION:

☐ Family Doctor
☐ Nurse Practitioner
☐ Specialist
☑ Other (Specify) Emergency Department

Name: _____
Address: SPH, 1702 20th St W, Saskatoon, SK S7M 0Z9
Phone: (306) 655-5000
Fax: (306) 655-5963

REFERRAL TO:

☐ Next Available Cardiologist
Except Dr._____

☐ Specific Dr._____

☐ Urgent (Explain): _____
_____

REASON FOR REFERRAL: *CHECK REASON AND INCLUDE REFERRAL LETTER, RELEVANT PREVIOUS DOCUMENTATION - DIAGNOSTIC LABS OR IMAGING, ECG (IF AVALIABLE), CONSULTS, INTERVENTIONS, PREVIOUS CARDIAC INVESTIGATIONS, AND SURGICAL REPORTS.*

☐ None Available

PLEASE NOTE THAT ANY FURTHER INVESTIGATIONS WILL BE ARRANGED BY THE RECEIVING CARDIOLOGIST.

Chest Pain	☐ Stress Test Only ☐ Chest Pain Consult ☐ Known Coronary Disease Assessment
Arrhythmia	☐ Palpitations Not Yet Determined ☐ Syncope ☐ Known Arrhythmia: _____ ☐ Cardio Electrophysiology Assessment (Catheter Ablation/ICD Assessment) Describe: _____
Congestive Heart Failure	☐ Dyspnea ☐ Known Congestive Heart Failure: _____
Murmur/Valvular Disease	☐ Known Valvular Disease: _____ ☐ New Murmur
Congenital Heart Disease	☐ Specify Diagnosis: _____
Aortic Disease	☐ Specify Diagnosis: _____
Other	☐ Please Describe: _____

NOTES:

POOLED REFERRAL INFORMATION: Patients offered the pooled referral option will receive the next available appointment with a specialist able to treat the referring condition. Specialists who choose to pool their referrals but do not share an office may use the Referral Management Service at eHealth Saskatchewan to manage the intake of patient referrals. This service shares de-identified referral information with all the specialists in this group to aid in reducing patient wait times and improving the patient experience.

Physician Signature:	Date:
Redirecting Specialist: ☐ Pooled ☐ Specific Dr._____	Date: