Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Mazankowski Alberta Heart Institute
Single Point of Access Referral

Emergent or Urgent After Hours Referral DO NOT fill out this form. Call 1.800.282.9911 RAAPID North.

Triage guidelines can be found on page two.

☐ **Urgent Referral (8 a.m. - 4 p.m. Monday to Friday) -** Call Cardiac Navigation Office at **1.866.772.0774**
Fax completed form to **780.407.7113**

☐ **Semi Urgent and Non Urgent -** Fax completed form to **780.407.6452**

Triage Guidelines (Please check applicable boxes below)

Triage Category	Symptoms *(including but not limited to)*	Response Time
Emergent	Acute or unstable MI ☐ Unstable Angina with chest pain ☐ Bacterial Endocarditis proven or suspected ☐ Suspected aortic dissection ☐ Suspected cardiac tamponade	Same day
Urgent	☐ Patients with cardiac conditions that are not emergent, but are deemed likely to deteriorate if not seen by a cardiologist within one week	Seen within one week
Semi-Urgent	☐ Known or suspected cardiac conditions that require quick cardiac assessment more urgently than the routine time frame	Seen within four weeks
Non-Urgent	☐ All other cardiac conditions that can be seen through the existing elective system	Seen within six weeks

Treatment will be delayed if form is missing or has incomplete information.

Please complete all sections of this form. For questions or for more information please call **1-866-772-0774**.

Patient Information

Last Name	First Name		
Gender	Weight *(kgs/lbs)*	Date of Birth *(yyyy-Mon-dd)*	PHN
Address	City	Prov	Postal Code
Phone *(home)*	Phone *(alternate)*		
Name of Contact Person	Contact Phone		

Special Needs *(check all that apply)*

☐ Communication ☐ Language ☐ Wheelchair ☐ Oxygen
☐ Antibiotic resistant organisims ☐ Other _____

Reason for Referral

☐ New Referral ☐ Re - Referral

☐ Chest Pain ☐ Atrial Fib ☐ Pre-Operative Consult ☐ Valve Disease
☐ Palpitations ☐ Abnormal ECG ☐ Syncope/Presyncope ☐ Arrhythmia
☐ Congestive Heart Failure ☐ CAD Assessment ☐ Shortness of Breath
☐ Other (specify) _____

Ensure the following supporting documents are provided with this referral:
☐ All medications and dosages
☐ Tests including history, ECG, diagnostic imaging, recent lab, and blood work

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Referring Physician

Name		Referring Physician Practice ID	
Address	City	Province	Postal Code
Phone		Fax	
Family Physician *(if different from referring source)*		Family Physician Practice ID	

Cardiologist *(Note this referral will be placed with the first available provider unless a preferred cardiologist is specified)*

Name of preferred clinic or cardiologist requested

Additional Comments

Referring Source Signature	Date *(yyyy-Mon-dd)*

Office Use Only

Date referral received *(yyyy-Mon-dd)*	Date referral reviewed *(yyyy-Mon-dd)*	Date referral accepted *(yyyy-Mon-dd)*
Appointment Date *(yyyy-Mon-dd)*	Date referral cancelled *(yyyy-Mon-dd)*	
Office notes		