CARDIAC REFERREL PROFORMA

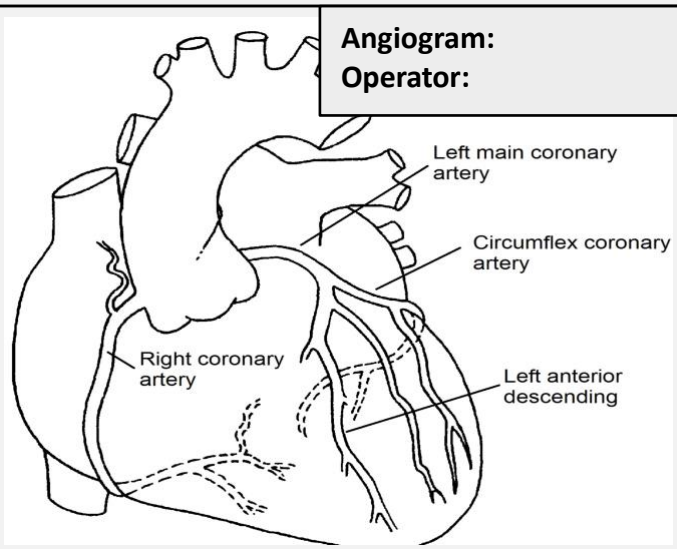
Name:
D.O.B:
Hospital no:

Referring Hospital:
Referring Cardiologist:
Date of Referral:
Date of Admission:

Presenting Complaint:

CCS:
NYHA:
MI (STEMI/NSTEMI):
Date of MI:
Troponin levels:
PVD:
TIA:
Stroke:
Asthma:

Angiogram:
Operator:



Cardiac risk factors:
Hypertension:
Hypercholesterolemia:
Diabetes:
Smoking:
Family history of IHD/CVD:

Echocardiogram: TOE/TTE

Date:
LV/RV function:
Valvular lesion:

Past Medical History:
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.

Carotid Dopplers:

Date:
Results:

Lung Function Tests/ Spirometry:
Date:
FEV1:
FVC:
TLCO:
KCO:

Anticoagulation Medication:
Date Stopped:

Aspirin:
Clopidogrel:
Warfarin:

Ticagrelor:
DOAC:
Enoxaparin:

Conduits:
Vein Mapping:

Dental Review:

Proposed Surgical procedure:

Pending Issues: