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# CARDIO-ONCOLOGY REFERRAL FORM

(For BCCA use only)

☐ First Available Cardiologist
☐ Dr. L. Dewart MSP: 62888
☐ Dr. C. Franco MSP: 67564
☐ Dr. P. Gladstone MSP:68795
☐ Dr. J. Rajala MSP:66034
☐ Dr. K. Wallace MSP 67961

Patient Name:

DOB:

PHN:

Contact #:

**Urgency of Referral**

☐ <1-2 weeks

☐ 3-4 weeks

☐ Non-urgent

**Reason for Cardiology Referral:**

☐ Chest pain
☐ Heart failure
☐ Low or dropping EF
☐ Cardiac optimization prior to treatment
☐ Arrhythmia
☐ Previous history of CAD
☐ Other:____________________________

| ONCOLOGY HISTORY | |
|---|---|
| Oncology Diagnosis | |
| Chemotherapy (include start & end dates) | Protocol:<br>Cycles: |
| Anthracycline: | Drug:<br>Total Dose: ________ mg/m2<br>Date given: |
| Radiation: | Site:<br>Dose:<br>Date: |

| Additional Info to Please Include with Referral: | |
|---|---|
| ▪ Echo reports and/or MUGA reports<br>▪ BCCA clinic notes<br>▪ Recent Medication List | ☐ Please do NT-pro-BNP if referral for CHF or dropping EF |

Referring Physician Name and Signature:
MSP# :