List of Urgent, Semi-Urgent, and Elective Outpatient Referral Types to Cardiology in Victoria, BC

General Cardiology Referrals – if unsure of how a patient should be triaged or if the question may be answered by phone, please contact the RACE cardiologist for discussion.

Urgent presenting issues (not all inclusive). To be seen in < 2 weeks:

- Chest pain/angina with minimal exertion or at rest (CCS III-IV)
- Rapidly progressive chest pain/angina/crescendo angina
- Severe and large amount of anterior ischemia on ischemia testing
- **Severe** valvular disease (stenosis or regurgitation)
- LVOT obstruction/gradient > 100 mmHg
- Shortness of breath with minimal exertion/rest that is cardiac in nature (NYHA III-IV)
- Newly diagnosed cardiomyopathy with LVEF <40%
- Severe thoracic aortic enlargement/dilatation/aneurysm > 5 cm
- Unexplained syncope/fainting/passing out
- Persistent bradycardia < 40 bpm
- Symptomatic pause >3 seconds in sinus rhythm or > 5 seconds in atrial fibrillation on Holter monitor
- Pregnant women with cardiac issues (time-sensitive)

Semi-Urgent presenting issues (not all inclusive). To be seen in < 6 weeks:

- 70% or greater stenoses/blockages on angiogram/cardiac CT scan that does not involve the left main or proximal LAD
- Severe and large amount of ischemia (not anterior)
- Recent ACS/MI < 6mo
- Arrhythmia with difficult to control symptoms
- Recent HF hospitalization (< 6mo)
- Recent diagnosis aortic dissection (< 6mo)
- Cardiac sarcoid
- Cardiac amyloid
- Pericarditis/myocarditis

Elective presenting issues (not all inclusive):

- Stable angina (CCS I-II)
- Coronary calcifications on CT scan
- Less than severe valvular disease
- Known mechanical/biological valve replacement that needs reassessment
- Hypertrophic cardiomyopathy/HOCM (gradient < 100 mmHg or no gradient)
- Shortness of breath that is likely cardiac (NYHA I-II)
- Cardiomyopathy with LVEF > 40%
- Aortic enlargement/dilatation/aneurysm < 5 cm
- Chronic aortic dissection

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- Atrial fibrillation with controlled symptoms
- Palpitations
- Congenital heart disease
- Stroke workup
- Pre-op consult

EP Referrals -in most cases, these patients will be under specialist care. Electrophysiology referrals should come from an internist or a general cardiologist.

Urgent presenting issues (not all inclusive):
- Syncope with structural heart disease or suspected channelopathy
- VT (ventricular tachycardia)
- Consideration for permanent pacemaker (eg – Mobitz II, complete heart block, sick sinus syndrome)
- Cardiac arrest
- Suspected pacemaker/ICD malfunction

Semi-Urgent presenting issues (not all inclusive):
- ICD consideration for primary prevention
- Highly symptomatic/uncontrolled atrial fibrillation or atrial flutter for consideration of ablation procedures
- Pacing induced cardiomyopathy
- Unexplained syncope for consideration of loop recorder

Elective presenting issues (not all inclusive):
- Routine consideration of atrial fibrillation or atrial flutter ablations
- Supraventricular tachycardia
- Wolff Parkinson White Syndrome
- Premature ventricular contractions (>20%) suspected to cause cardiomyopathy
- Suspicion of inherited arrhythmia without symptoms

Interventional Cardiology Referrals -in most cases, these patients will be under specialist care. Direct interventional cardiology referrals should come from an internist or a general cardiologist.

Urgent Presenting Issues (not all inclusive):
- Accelerating angina
- Significant left main or proximal LAD disease on imaging for consideration of coronary angiography

Semi-urgent Presenting Issues (not all inclusive):
- Evidence of obstructive CAD that is not well managed with medical therapy for consideration of coronary angiography