Sunnybrook
SCHULICH HEART CENTRE

SCHULICH CARDIO-OBSTETRICS CLINIC

Referral Form

Dr. Jennifer Amadio, MD MEHP FRCPC
Sunnybrook Health Sciences Centre
2075 Bayview Ave, Toronto, ON M4N 3M5
Phone: 416-480-4822 | Fax: 416-480-4722

Program Description

The **Schulich Cardio-Obstetrics Clinic** is a dedicated cardiology clinic catering to the unique needs of women in the following categories: (1) those who have pre-existing heart conditions pre pregnancy or experience heart disease during pregnancy, delivery or post-partum, (2) pregnant women displaying symptoms of heart disease (3) and (4) women who have experienced cardiac complication during prior pregnancies. Our clinic works close in coordination with the Dan Women's and Babies Program at Sunnybrook. We have established partnerships with a team of specialists including obstetricians, maternal fetal medicine physicians, anesthesiologists, neonatologists, internal medicine specialists, endocrinologists, medical geneticists, and pharmacists to ensure our patients receive comprehensive and tailored care.

Consultations in this clinic require referral from a physician or advanced practice provider. Referrals will be triaged according to urgency of symptoms, diagnosis, and expected date of delivery. Please complete the form in its entirety. Incomplete forms will be returned. Please include all relevant medical reports, labs, consult notes, and/or cardiac test results.

Patient Demographics

Surname:	First name:	DOB (yyyy/mm/dd)	Health Card No. & Version Code:

Address:	City:	Province:	Postal Code:

Telephone:	Alternate Phone:	Sex:	Preferred Language:

Clinical Information *(*fields are mandatory)*

Reason for Referral:*

Maternal age*_____Gestational age*_____
Last Menstrual Period* (yyyy-mm-dd):_____
Expected due date*(yyyy-mm-dd): _____
Previous pregnancy complications (if applicable):

- O Preeclampsia/eclampsia
- O Gestational hypertension
- O Gestational diabetes
- O Other (please specify):_____

Cardiac History* (check if applicable)

- O Peripartum cardiomyopathy
- O Other cardiomyopathy / heart failure
- O Non-complex congenital heart disease (ASD, VSD, etc.)
- O Native valve dysfunction (BAV, rheumatic etc.)
- O Mechanical or Bioprosthetic valve(s) _____
- O Aortopathy
- O Arrhythmias (SVT, AF/flutter, VT, bradyarrhythmias)
- O Cardiac devices (pacemaker, ICD, CRT)
- O Cardiac chest pain / previous coronary syndrome
- O Spontaneous Coronary Artery Dissection (SCAD)
- O Myocardial Infarction (MI)
- O Pericardial disease
- O Pre-pregnancy counselling in cardiac patients
- O IVF / assisted reproduction in cardiac patients
- O Other (please specify):_____

Referring Physician / Advanced Practice Provider (i.e. NP, PA)

FULL NAME (print):	COLLEGE NO / BILLING NO:	SIGNATURE:

FULL ADDRESS (HOSPITAL/OFFICE NAME, STREET, CITY, PROVINCE, POSTAL CODE):		
TELEPHONE	FAX:	Requested Urgency: ☐ < 3 weeks ☐ 1-2 months ☐ > 2 months

Please remember to include all relevant medical reports, labs, consultation notes, and cardiac diagnostic testing reports.