Cardiac Amyloid Referral Form

Kawartha Cardiology Clinic

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Date of Referral: (YYYY/MM/DD)

Name of Referring:

Billing #:

Address:

Tel:

Fax:

PATIENT INFORMATION

Name:

Address:

Phone #:

DOB:

Health card #:

Family Physician Name:

Reason for Referral

☐ Wild-type TTR amyloid

☐ AL amyloid

☐ Hereditary TTR amyloid

☐ Unsure

Please include ALL of the following documents (check all boxes that apply if sent/completed):

☐ Clinic Note (with NYHA Class assessment)

Diagnostic Imaging: ☐ Echocardiography (investigation for LVSd greater than 12mm for TTR)

☐ PYP Scan OR Cardiac Biopsy (circle test)

Bloodwork: ☐ SPEP/UPEP/Free light Chains (AL Bloodwork)

☐ TTR gene screen (Bloodwork for Molecular Diagnostics sent to London

Note:

Once required testing for diagnosis received we can determine next steps for treatment with patient and coordinate drug access. If this testing is negative then will be referring back to the family physician or general cardiologist.

Referring Physician's Signature

Date