

### Program Description

The **Cardio-Obstetrics Clinic** is a specialized cardiology clinic for women with: (1) established heart disease pre-pregnancy, during pregnancy, delivery, and post-partum (2) pregnant women with symptoms of heart disease or (3) women with previous cardiac complications of pregnancy. We are closely linked to the University of Ottawa Heart Institute (UOHI) Women's Heart Health Centre, UOHI CardioPrevent Post-Partum Rehabilitation Program and the UOHI Adult Congenital Heart Disease Clinic. We collaborate with obstetricians, maternal fetal medicine physicians, anesthesiologists, neonatologists, internal medicine specialists, endocrinologists, medical geneticists and cardiac rehabilitation.

**Consultations in this clinic require referral from a physician or nurse practitioner. Referrals are quickly 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.**

Please note: patients known to the UOHI Adult Congenital Heart Disease clinic or those with complex congenital heart disease (e.g. Tetralogy of Fallot, Fontan, Eisenmenger's, cyanotic congenital heart disease etc.) should be referred there first.

### 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)

<p>Reason for Referral:*</p>  <p>Maternal age* _____ Gest age* _____</p> <p>G____ T____ P____ A____ L____ status*</p> <p>Last Menstrual Period* (yyyy-mm-dd): _____</p> <p>Expected due date* (yyyy-mm-dd): _____</p> <p>Previous pregnancy complications (if applicable):</p> <p><input type="checkbox"/> Preeclampsia/eclampsia</p> <p><input type="checkbox"/> Gestational hypertension</p> <p><input type="checkbox"/> Gestational diabetes</p> <p><input type="checkbox"/> Other (please specify): _____</p>	<p><b>Cardiac History* (check if applicable)</b></p> <p><input type="checkbox"/> Peripartum cardiomyopathy</p> <p><input type="checkbox"/> Other cardiomyopathy / heart failure</p> <p><input type="checkbox"/> Non-complex congenital heart disease (ASD, VSD, etc.)</p> <p><input type="checkbox"/> Native valve dysfunction (BAV, rheumatic etc.)</p> <p><input type="checkbox"/> Mechanical valve(s) _____</p> <p><input type="checkbox"/> Bioprosthetic valve(s) _____</p> <p><input type="checkbox"/> Arrhythmias (SVT, AF/flutter, VT, bradyarrhythmias)</p> <p><input type="checkbox"/> Cardiac devices (pacemaker, ICD, CRT)</p> <p><input type="checkbox"/> Cardiac chest pain / previous coronary syndrome</p> <p><input type="checkbox"/> Pericardial disease</p> <p><input type="checkbox"/> Pre-pregnancy counselling in cardiac patients</p> <p><input type="checkbox"/> IVF / assisted reproduction in cardiac patients</p> <p><input type="checkbox"/> Other (please specify): _____</p> <p>_____</p> <p>_____</p>
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### Referring Physician / Practitioner

FULL NAME (print):	COLLEGE NO / BILLING NO:	SIGNATURE:
FULL ADDRESS (HOSPITAL/OFFICE NAME, STREET, CITY, PROVINCE, POSTAL CODE):		
TELEPHONE	FAX:	Requested Urgency: <input type="checkbox"/> < 4 weeks <input type="checkbox"/> 1-2 months <input type="checkbox"/> > 2 months

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