



Vascular Risk and Prevention Clinic Referral

Advanced secondary prevention for patients with high risk ASCVD

Date of Referral: _____

Patient Information			
First Name:		Last Name:	
		Date of Birth (ddMmmyyyy)	
PHN	MRN (Optional):	Primary Phone #:	
Email:		Special Instructions:	
Provider Information			
Referring Provider:		MSP #:	<input type="checkbox"/> Locum
Clinic Name:		Phone#:	Fax#:
Street Address:			
Primary Care Provider:		<input type="checkbox"/> Same as ordering provider	Copy to (full name):
Indication for Referral			
CAD: <input type="checkbox"/> Premature CAD (M<55, F<65) <input type="checkbox"/> Prior Revascularization (PCI / CABG) <input type="checkbox"/> Recurrent ACS Events		PAD: <input type="checkbox"/> Claudication <input type="checkbox"/> Prior Revascularization <input type="checkbox"/> Recurrent Limb Events	
DYSLIPDEMIA: <input type="checkbox"/> Suspicion of Genetic Dyslipidemia (LDL>5Mm) <input type="checkbox"/> Inability to achieve target LDL <input type="checkbox"/> Consideration for Advanced Lipid Lowering Therapy		ANTOTHROMBIC THERAPY: <input type="checkbox"/> Consideration for Advanced Antithrombic Therapy	
Pertinent Medical History			
Fax Routing Royal Jubilee Hospital, Royal Block, 3 rd Floor Phone: 250-370-8111 Ext.12099 Fax: 250-370-8267			
Office Use Only			
Date Received:			

