REFERRAL FORM

Dr. Roland Beaulieu, F.R.C.P. (C)

Consultant in Paediatric and Fetal Cardiology

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Website: www.yourkidsheart.ca

☐ **Paediatric echo with consultation** ☐ **Fetal echo with consultation** **EDC:** _____

Patient Information

Health Card Number: _____ Version code: _____ DOB: _____ Sex: M ☐ F ☐

Last Name: _____ First Name: _____

Address_____ City: _____ Postal Code: _____

Phone #:_____ Cell #:_____ Other: _____

Reason for Referral/Patient History

Please provide physical findings (i.e. birth weight, current weight, height, vital signs), medications, allergies, previous surgeries, family history:

_____

_____

_____

_____

Please attach relevant reports:

- ☐ Blood Work
- ☐ Holter report
- ☐ ECG
- ☐ Ultrasound (fetal patients)
- ☐ Chest x-ray
- ☐ Echo report
- ☐ Baby history questionnaire- under 2 months (refer to **FORMS** on our website)

Please check the preferred location:

☐ **Orillia** - 119 Memorial Ave, unit 104
Orillia, ON L3V 5X1

☐ **Barrie**- Royal Victoria Regional Health Centre (RVH)
201 Georgian Drive
Barrie, ON L4M 6M2

Referring Professional:

Name: _____ **Billing Number:** _____

Professional Designation: _____

Address: _____

_____

Phone: _____ Fax: _____

Copy reports to other Physicians: _____

Phone#/Fax#:_____

Doctor's Signature: _____

Please be advised patients will be contacted with an appointment by our office staff.