Cincinnati Children's
changing the outcome together

Cardiovascular Genetics Referral Form

Name: _____

DOB: _____

MRN: _____

Fax or Email Referral to: 513-803-1748 or CardiologyGC@cchmc.org

Patient Name: _____ DOB: _____

Parent's Name(s) (if pediatric patient): _____

Home Phone: _____ Work Phone: _____

Address: _____

Referring Physician: _____ Contact Person: _____

Office Number: _____ Fax Number: _____

Address: _____

Referred for:

☐ Cardiology Genetic Counseling ☐ Marfan and Aortic Diseases Clinic ☐ Cardiology Geneticist Exam

Reason for referral (check all that apply):

Cardiomyopathy

☐ Hypertrophic cardiomyopathy (HCM), obstructive or non-obstructive

☐ Dilated cardiomyopathy (DCM)

☐ Peripartum cardiomyopathy

☐ Left ventricular non-compaction (LVNC)

☐ Arrhythmogenic cardiomyopathy (ARVC/D)

☐ Congestive heart failure (CHF)

Arrhythmia

☐ Long QT syndrome (LQTS)

☐ Brugada syndrome (BrS)

☐ Catecholaminergic polymorphic ventricular tachycardia (CPVT)

☐ Abnormal ECG (excludes LQTS)

☐ Personal history of sudden cardiac arrest (SCA)

☐ s/p ICD or pacemaker in situ

Aortopathy

☐ Concern for Marfan syndrome

☐ Known diagnosis of Marfan syndrome

☐ Thoracic aortic aneurysm or dissection

☐ Family history of aortic disease

Coronary Artery Disease

☐ Familial hypercholesterolemia

Genetics/Family History

☐ Healthy patient who has a gene mutation

☐ Family history of a gene mutation

☐ Family history of other cardiovascular disease

_____

Other

☐ _____

Family history of cardiovascular disease

Relation	Diagnosis	Age	Genetic Testing Completed? If yes, include specific gene and a copy of results if available

Please fax, or email, this form, along with relevant records (demographics, insurance card, most recent cardiology note, cardiac imaging, and information regarding previously completed genetic testing) to (513) 803-1748 or CardiologyGC@cchmc.org

For questions, please call the Division of Cardiology, 513-636-4432

Signature/Credentials Printed Name Date