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LIPID CLINIC REFERRAL

Jim Pattison Outpatient Care and Surgery Centre

Form ID: PMXX104704B Rev: January 12, 2024

Referring Health Care Provider	**Community Provider** *(if different from referring source)*
Name:	Name:
Billing number:	Billing number:
Phone:	Phone:
Fax:	Fax:
☐ GP ☐ Specialist ☐ NP ☐ Hospital ☐ ER ☐ Other: ________________________________	
☐ Patient does not have a Primary Health Care Provider	
Section 1 - Patient details	
Legal name:	Preferred name:
Date of birth (dd/mm/yyyy):	PHN:
Address (including postal code):	Phone number:
	Gender: ☐ Man ☐ Woman ☐ Other: __________________
Language(s):	Pronouns: ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ Other: __________________
Interpreter required: ☐ No ☐ Yes If yes, language: ________________________	
Email address: (Note- required for education classes and appointment notification)	

Section 2 - Reason for referral
Instructions: select all applicable referral reasons below, or indicate a reason for referral in the other section.
☐ Possible diagnosis of Familial Hypercholesterolemia or other genetic dyslipidemias
☐ Severe hypertriglyceridemia (Triglycerides > 10.0)
☐ Severe hypercholesterolemia (LDL > 5.0, ApoB > 1.45, Non-HDL > 5.8)
☐ Established atherosclerotic cardiovascular disease with LDL > 1.8 or ApoB > 0.7 despite statin therapy
☐ High risk primary prevention patients (e.g., diabetes, FRS > 20%, metabolic syndrome, age < 40 plus LDL > 3.5)
☐ Cardiovascular risk assessment (family history of premature coronary artery disease: males < 55; females < 65)
☐ Severely low HIDL (< 0.6)
☐ Subclinical atherosclerosis (i.e., coronary artery calcium > 0)
☐ Elevated Lipoprotein (a) (> 500 mg/L or > 100 nmol/L)
☐ Suboptimal response to initial therapy and/or need for combination therapy
☐ Intolerance or adverse reactions to lipid lowering therapy or interactions with current lipid lowering therapy
☐ Dyslipidemia and pregnancy
☐ Other (specify):
☐ **Urgent referral** (e.g., recent MI with suboptimal lipid control and/or need for urgent PCSK9 inhibitor use, triglycerides > 20) Indicate reason: ____ *Note:* We will try our best to accommodate urgent patients within one to two months
Section 3 - Additional information
• Attach lipid profile within the last six (6) months (including total cholesterol, LDL, HDL, Triglycerides, TC/HDL ratio) • Attach full medical history, medications and any relevant consults or diagnostics • Refer to back of page 1 for more information

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Referral Process
• You will be notified that we have received the referral via fax. • Appointment date and times are booked three months in advance. • Once booked, you will receive a second notification with details of appointment via fax. • A notification will also be emailed to client. • If the information on this form is incomplete, referrals will **not** be processed and sent back to the referring practitioner • Due to high volumes, expect a lengthy wait time for a consultation.

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