Cardiology Second Opinion Family Referral Form

Ann & Robert H. Lurie Children's Hospital of Chicago®

1. You can leave areas blank that are not applicable. Please email the completed form to **HeartCenter2ndOpinion@luriechildrens.org.**
2. Please send/fax OR reports, imaging reports and clinical notes that apply. Fax to: **312.227.9640, ATTN: Silvana Illescas**
3. Imaging can be sent via Life Image.

If you have any questions, please contact us at PSO team at HeartCenter2ndOpinion@luriechildrens.org or 312.227.4240.

PLEASE PRINT CLEARLY

PATIENT NAME	DATE OF BIRTH	SEX
REQUESTOR'S NAME		
RELATIONSHIP TO PATIENT	FAX	PHONE
CARDIOLOGIST		*Is your cardiologist aware you are seeking a second opinion?* ☐ YES ☐ NO
CURRENT/PAST CARDIAC SURGEON		
CURRENT TREATMENT CENTER	FAX	PHONE
PRIMARY CARE PROVIDER	FAX	PHONE

DIAGNOSIS *(What is the patient's cardiac diagnosis? E.g., Tetralogy of Fallot, atrial septal defect, pulmonary valve stenosis, etc.)*

ADDITIONAL CARDIAC MEDICAL HISTORY (*Does the patient have any additional cardiac diagnoses other than what you are seeking a second opinion for?)*

CARDIAC SURGICAL HISTORY
(Has the patient had surgery for their cardiac diagnosis/diagnoses? If YES, please list the procedure, where the surgery took place, and the date of the procedure.)

IMAGING AND TESTING *(Any testing the patient has received — provide date of test and how we will receive the test results, if applicable.)*

☐ ECG	DATE:	RECEIVING METHOD:
☐ ECHO	DATE:	RECEIVING METHOD:
☐ CARDIAC MR	DATE:	RECEIVING METHOD:
☐ CARDIAC CT	DATE:	RECEIVING METHOD:
☐ HOLTER/EVENT MONITOR	DATE:	RECEIVING METHOD:
☐ LABS *(blood work, etc.)*	DATE:	RECEIVING METHOD:

NON-CARDIAC MEDICAL/SURGICAL HISTORY
(*Does the patient have any non-cardiac related medical or surgical history? If so, list diagnosis, surgery, and/or what specialty they are followed by.)*

KD.11.2020