AASPIRE THE AA-Clozapine PATIENT CARE NETWORK

AA pharma

AA-CLOZAPINE PATIENT CARE NETWORK

CARDIOLOGY CONSULT INITIAL CHECKLIST

Date:	# of pages incl. cover:
To:	**AA-CLOZAPINE Patient Care Network** — **Tel: 1-877- 276-2569** **Fax: 1-866-836-6778**
Tel:	Email: aaspire@aapharma.ca
Fax:	Website: www.aaspire.ca

Patient PIN: _____

Date of Birth: _____

Age: _____

Gender: _____

Healthcare Number: _____

Physician Name: _____

Telephone: _____

Fax: _____

Email address: _____ (Required by Cardiologist for contact with Physician)

Provide the following information for the Initial Assessment:

Relevant Past Medical History:

☐ Cardiovascular Risk Factors (**Please circle below all relevant for the patient)**

- Hypertension
- Diabetes
- Dyslipidemia
- Smoker
- Family History of Premature ischemic heart disease
- Obesity

- Autoimmune disease (i.e. Rheumatoid Arthritis, Lupus)
- History of Gestational hypertension or Gestational diabetes

☐ Coronary Artery Disease

- **If Yes** please provide details of relevant investigations and therapeutic interventions (i.e. dates and results of most recent Stress Tests, Myocardial Perfusion Imaging, Stress Echocardiogram, Angiography, Percutaneous Coronary Artery Intervention (PCI) or Coronary Artery Bypass Grafting (CABG).

Comment:

_____
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☐ Structural heart disease:

- Previous Myocarditis, Heart Failure, Valvular Heart Disease , Congenital heart disease
- **If Yes** please provide dates and details of any interventions or corrective surgeries (valve repair or replacement procedures) and recent investigations including assessment of Left Ventricular Ejection Fraction (LVEF) via Echocardiogram, Cardiac MRI or Nuclear Wall Motion Study.

Comment:

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☐ Pericardial Disease

- Pericarditis, Myopericarditis, Pericardial Effusion, Constrictive pericarditis.
- **If Yes** please provide details including relevant investigations and treatment.

Comment:

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☐ Heart Rhythm Disorder:

- Any Arrhythmia, atrial fibrillation, atrial flutter, SVT, VT, Sudden Cardiac Death, Prolonged QT, Pacemaker or ICD.
- **If Yes** please provide details including relevant investigations and treatment.

Comment:

_____
_____
_____

☐ Thrombosis, DVT or PE

- **If Yes** please provide details including relevant investigations and treatment.

Comment:

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_____
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☐ EtOH Exposure, Illicit Drug Use

Comment:

_____
_____
_____

☐ Other significant medical history

Comment:

_____
_____
_____

Current Medications and History of Clozapine Therapy:

☐ History of Clozapine use

Comment:

_____
_____
_____

☐ Other Current Medications

Comment:

_____
_____
_____

☐ Drug Allergies

Comment:

_____
_____
_____

Current Symptoms & Assessment to Date:

☐ Current Symptoms:

- Chest pain, dyspnea, palpitations, presyncope, syncope, fatigue, malaise, edema, fever, rash.

Comment:

_____
_____
_____

☐ Vital Signs- HR/BP/Temp/O2 sat (if available)/Body Mass Index or Height and Weight.

Comment:

_____
_____
_____

☐ Bloodwork- Pretreatment (if available) and current- CBC and differential, ESR or CRP, Troponin, BNP, HbA1c, lipids.

Comment:

_____

_____

_____

☐ 12 Lead ECG (Pretreatment and current if available)

Comment:

_____

_____

_____

☐ Chest X-Ray (PA and LAT),

Comment:

_____

_____

_____

☐ Transthoracic Echocardiogram (Pretreatment and current if available)

Comment:

_____

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Additional Comments:

_____

_____

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_____

Upon completion please have the information together with this cover faxed to **1-866-836-6778**.

Thank you for your assistance, should you have any questions or concerns or require any assistance please do not hesitate to contact us at **1-877-276-2569**. We would be more than happy to assist you.