Cardio 1

CARDIOLOGY REFERRAL

Provider Name: _____
Family Physician: Yes? ☐ No? ☐
Clinic / Hospital: _____
Address: _____
_____
Phone: _____
Fax: _____
Date: _____

PATIENT INFORMATION

Name: _____
PHN: _____ MHSC# _____ ☐ Male
DOB: (dd/mmm/yy) _____ ☐ Female
Address: _____ ☐ Other _____
City: _____ Province: _____
Postal code: _____ Email: _____
Home phone # _____
Cell: _____
Work: _____
Other Patient Details: _____

☐ Outpatient ☐ Inpatient – site: _____

REFER TO: ☐ Specific Cardiology Specialist: _____ ∗OR∗ ☐ Earliest Available

1) APPOINTMENT

☐ **Urgent** (Typically Within 1 to 2 weeks) **Please Call us if Appt is required sooner**

☐ **Semi-Urgent** (Typically Within 2 to 4 weeks)

☐ **Elective** (An attempt will be made to be seen within 4 - 8 weeks)

2) REASON FOR REFERRAL (Check all that apply)

☐ Angina / Chest Pain NYD
☐ Post ACS CAD
☐ Chronic CAD
☐ Peripheral Artery Disease
☐ Atrial Fibrillation
☐ Arrhythmia NYD
☐ Heart Failure
☐ Cardiac Murmur
☐ Cardiovascular Risk Factors (Including DM2, HTN, Dyslipidemia)
☐ Other: _____

3a) AVAILABLE TESTING

☐ Ambulatory BP Monitoring ($)
☐ Cardiac Stress Testing
☐ ECG Testing and Interpretation
☐ Bedside Echocardiogram ($)
☐ ABI (Ankle-Brachial Index) Test ($)
☐ Holter Monitoring ($)

3b) Indication: _____

All testing will be subject to review and performed in consultation with one of our physicians

($): Fees may apply for uninsured services related to these tests

Please include recent relevant medical history, medication records, investigations and lab results

This referral will be triaged by cardiology staff. For prompt booking, please ensure all sections are fully completed.

Signature: Date:

Cardio 1
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