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
2-230 Osborne Street, Winnipeg, MB, R3L1Z5
Ph: 204-287-5222 Fax: 204-287-5223