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:**

1) APPOINTMENT

☐ Urgent
☐ Semi-Urgent
☐ Elective

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: _____

3b) Indication: _____

****Diagnostic test may be performed at the Cardiologist discretion****

($): Fees may apply for uninsured services

☐ **Please include recent relevant medical history, medication records, investigations and lab results. Any "Arrhythmia" and "Abnormal ECG/EKG" referrals. Please include recent EKG results. Check box if attached.**

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