Cardio 1

DIAGNOSTIC REFERRAL

Diagnostic testing only

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: _____

Height _____ Weight _____

1) RESPIROLOGY: Spirometry testing

☐ **Simple Spirometry (NO BRONCHODILATION)** **Indication:**_____

☐ **Spirometry with Bronchodilator (PRE & POST)**

2) CARDIOLOGY: Available Testing

☐ **Ambulatory BP Monitoring ($)**

☐ **Cardiac Stress Testing**

☐ **ECG Testing and Interpretation**

☐ **ABI/TBI (Ankle-Brachial Index & Toe-Brachial Index) Test**

3) Indication:_____

($): Fees may apply for uninsured services

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

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

Signature: Date:

Cardio 1
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