

**PATIENT INFORMATION:**

**REFERRING PHYSICIAN:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 DOB:(mm/dd/yyyy) \_\_\_\_\_  
 Health Card Number: \_\_\_\_\_ VC: \_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Gender:  Female  Male  \_\_\_\_\_

Can the Patient Exercise on a Treadmill:  Yes  No  
 Level of Urgency:  Urgent  Elective

**INDICATION: Check all that apply**

*\*consultation will be arranged if there are high risk features on diagnostic testing*

- Chest Pain – Consider: Echo & Appropriate Stress Testing
- Dyspnea – Consider: Echo & Appropriate Stress Testing
- Palpitations – Consider: Echo & 48-Hour Holter Monitor
- Syncope – Consider: Echo & 48-Hour Holter Monitor
- Atrial Fibrillation – Consider: Echo & 48-Hour Holter Monitor
- Cardiac Source of Embolism – Consider: Echo & 14-Day Holter Monitor
- High Risk CV Profile – Consider: Echo & Appropriate Stress Testing
- Murmur – Consider: Echo
- Other – Please specify indication below and select appropriate testing

Echocardiography	<input type="checkbox"/> Echocardiogram
Monitoring	Holter Monitoring: <input type="checkbox"/> 24 hr <input type="checkbox"/> 48 hr <input type="checkbox"/> 72 hr <input type="checkbox"/> 14 Day Ambulatory Blood Pressure Monitor: <input type="checkbox"/> 24 hr <i>(\$75 fee, cash or cheque only; not covered by Ohip)</i>
Stress Testing	<input type="checkbox"/> Treadmill Stress Test <i>(Patient has no physical, cognitive or other impediment to exercise)</i> <input type="checkbox"/> Exercise Stress Echocardiogram <i>(Abnormal ECG, LVH, prior CABG, Digoxin use)</i> <input type="checkbox"/> Stress Test with Consult <input type="checkbox"/> Stress Test +/- Consult <i>(Consult will be added if reading cardiologist deems appropriate)</i>

**Please provide all relevant clinical information:**

Physician's Signature: \_\_\_\_\_ Billing #: \_\_\_\_\_ Date: \_\_\_\_\_