

Good Health CPS Guelph Clinic

350 Eramosa Road, Unit 1 Guelph, ON, N1E 2M9

Tel: 226-807-6600 Fax: 226-770-5338

goodhealthcps@goodclinic.ca

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 with consultation Dyspnea – Consider: Echo & Appropriate Stress Testing with consultation 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 with consultation Murmur – Consider: Echo	PATIENT INFORMATION	N:	REFERRING PHYSICIAN:	
Address:			_	
Phone: Gender: Female Male Gender: Gende				
Email: Gender: Female Male			- -	
Gender: Female Male	Fmail:			
Can the Patient Exercise on a Treadmill:				
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□ Dyspnea − Consider: Echo & Appropriate Stress Testing with consultation □ 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 with consultation □ Murmur − Consider: Echo □ Other − Please specify indication below and select appropriate testing Echocardiography				
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☐ Murmur – Consider: Echo ☐ Other – Please specify indication below and select appropriate testing Echocardiography ☐ Echocardiogram Monitoring Holter Monitoring: ☐ 24 hr ☐ 48 hr ☐ 72 hr ☐ 14 Day Ambulatory Blood Pressure Monitor: ☐ 24 hr (\$75 fee, cash or cheque only; not covered by OHIP) Stress Testing ☐ Treadmill Stress Test with consultation ☐ Preadmill Stress Test (Test only) ☐ Exercise Stress Echocardiogram with consultation ☐ Exercise Stress Echocardiogram (Test only) ☐ Consultation requested if there are high risk findings on diagnostic testing ☐ Consultation	☐ Cardiac Source of Embolism – Consider: Echo & 14-Day Holter Monitor			
Other – Please specify indication below and select appropriate testing Echocardiography	☐ High Risk CV Profile – Consider: Echo & Appropriate Stress Testing with consultation			
Echocardiogram	☐ Murmur – Consider: Echo			
Monitoring Holter Monitoring: □ 24 hr □ 48 hr □ 72 hr □ 14 Day Ambulatory Blood Pressure Monitor: □ 24 hr (\$75 fee, cash or cheque only; not covered by OHIP) Stress Testing (Patient has no physical, cognitive or other impediment to exercise) Consult Consult Consult Consultation □ Consultation □ Exercise Stress Echocardiogram (Test only) □ Consultation □ Consultation □ Consultation □ Consultation	☐ Other – Please specify indication below and select appropriate testing			
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Ambulatory Blood Pressure Monitor: Stress Testing (Patient has no physical, cognitive or other impediment to exercise) Consult Consult Ambulatory Blood Pressure Monitor: 24 hr (\$75 fee, cash or cheque only; not covered by OHIP) Treadmill Stress Test with consultation Treadmill Stress Test (Test only) Exercise Stress Echocardiogram with consultation Exercise Stress Echocardiogram (Test only) Consultation requested if there are high risk findings on diagnostic testing Consultation	Echocardiography	☐ Echocardiogram		
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other impediment to exercise Stress Echocardiogram (Test only) Consult Consult Consultation requested if there are high risk findings on diagnostic testing Consultation	(Patient has no			
Consult Consult Consultation requested if there are high risk findings on diagnostic testing Consultation				
☐ Consultation	physical, cognitive or other impediment to	☐ Exercise Stress Echocardiogram	n with consultation	
Please provide all relevant clinical information:	physical, cognitive or other impediment to	☐ Exercise Stress Echocardiogram	n with consultation	
	physical, cognitive or other impediment to exercise)	☐ Exercise Stress Echocardiogram☐ Exercise Stress Echocardiogram☐ Consultation requested if there	n with consultation n (Test only)	
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Physician's Signature: _____ Billing #: _____ Date: _____