GOOD HEALTH
MARKHAM CARDIAC CLINIC

**Good Health Markham Clinic**
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**PATIENT INFORMATION:**

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

**REFERRING PHYSICIAN:**

_____
_____
_____
_____
_____

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

**INDICATION:** ***Check all that apply***

☐ Chest Pain ☐ Atrial Fibrillation ☐ Murmur ☐ Heart Failure
☐ Dyspnea ☐ Presyncope / Syncope ☐ Palpitations ☐ Cardiomyopathy
☐ High Risk CV Profile ☐ Cardiac Source of Embolism / Stroke

| | |
|---|---|
| Echocardiography | ☐ Echocardiogram |
| Monitoring | Holter Monitoring: ☐ 24 hr ☐ 48 hr ☐ 72 hr ☐ 14 Day<br>Ambulatory Blood Pressure Monitor: ☐ 24 hr *($75 fee, cash or cheque only; not covered by OHIP)* |
| Stress Testing | ☐ Treadmill Stress Test with consultation<br>☐ Exercise Stress Echocardiogram with consultation |
| Consultation | ☐ Consultation |
| Risk Modification Clinic | ☐ Risk Factor Modification Consultation<br>- Hypertension - Diabetes - Dyslipidemia - BMI > 30<br>- Current Smoker - CAD or PAD History - Family History of CVD<br>- Framingham Risk Score > 10% |

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

**Please provide all relevant clinical information:**

Physician's Signature: _____ Billing #: _____ Date: _____