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 Ambulatory Blood Pressure Monitor: ☐ 24 hr *($75 fee, cash or cheque only; not covered by OHIP)*
Stress Testing	☐ Treadmill Stress Test with consultation ☐ Exercise Stress Echocardiogram with consultation
Consultation	☐ Consultation
Risk Modification Clinic	☐ Risk Factor Modification Consultation - Hypertension - Diabetes - Dyslipidemia - BMI > 30 - Current Smoker - CAD or PAD History - Family History of CVD - 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: _____