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 ☐ _____
Language: ☐ Cantonese ☐ Mandarin ☐ Farsi ☐ Arabic ☐ Other _____

REFERRING PHYSICIAN:

_____
_____
_____
Billing #: _____

Physician Signature: _____
Date: _____

Can the Patient Exercise on a Treadmill: ☐ Yes ☐ No

Level of Urgency: ☐ Urgent (< 2 Days) ☐ Semi-Urgent (< 1 week) ☐ Elective ☐ Same Day *Please call

Consultation	☐ Cardiology Consultation ☐ Lipid Clinic (Primary and Secondary Prevention) ☐ Hypertension Clinic
Diagnostics	☐ Echocardiogram Holter Monitoring: ☐ 24 hr ☐ 48 hr ☐ 72 hr ☐ 14 Day Ambulatory Blood Pressure Monitor: ☐ 24 hr *($75 fee not covered by OHIP)*
Stress Testing	☐ Treadmill Stress Test with consultation ☐ Exercise Stress Echocardiogram with consultation

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	☐ Bradycardia	

Please provide all relevant clinical information: