CARDIAC REFERRAL FORM

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Patient Information

Name: First Name Name	DOB: Date / Month / Year
Address:	
Phone:	
Health Card Number:	

Patient Appointment Date: Date / Month / Year

Consult ☐ If urgent please call office

Echo ☐

Stress Test ☐ Exercise ☐ Myoview ☐ Persantine ☐ Stress Echo

Holter Monitor ☐ 24-hr ☐ 48-hr ☐ 72-hr ☐ 2-wk ☐ 4-wk

LER (Loop recorder) ☐ 2-wk ☐ 4-wk

Reason(s) for Referral:

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Post MI
- ☐ HTN
- ☐ Dizziness
- ☐ Syncope
- ☐ Fainting
- ☐ Bradycardia
- ☐ Other
- ☐ Abnormal ECG
- ☐ TIA
- ☐ Angina
- ☐ CVA
- ☐ Atrial Fib
- ☐ SOB
- ☐ Pacemaker
- ☐ Frequent Falls
- ☐ Murmur
- ☐ Cardiac Arrhythmias
- ☐ Unexplained Fatigue
- ☐ Family History of CAD
- ☐ Lightheadedness
- ☐ Post Angioplasty
- ☐ Pre-OP
- ☐ CAD

Patient History and Medications:

Referring Physician (Signature)

Family Physician/Copy to:

Please fax the form at 905-356-4344