

Outpatient Cardiology and Diagnostic Testing Referral Form



Phone: 905-577-1414

Fax: 905-577-8037

PATIENT INFORMATION - PLEASE COMPLETE					
Patient name:					
Address:					
Phone number:					
DOB:					
Health card #:					

REASON FOR REFERRAL - PLEASE COMPLETE						
☐ Cardiac Dia	Consultation DICATE CONSULT UR gnostic Testing RFORM CARDIAC TES	_	`	☐ Elective (2-6 weeks) ☐ Off cardiac medications		
Reason / clinical information (please attach	relevant information):		•			
CARDIOLOGY CONSULTATION	CARDIAC DIAGNOSTIC TESTING					
Cardiologist to determine most appropriate clinic OR Comprehensive Cardiology Clinic CV Risk Assessment and Prevention Arrhythmia / Device Clinic Cardio-Oncology Clinic Congenital Heart Disease Clinic Heart Function Clinic Interventional Cardiology Clinic Post-Surgical Cardiovascular Clinic Valve Clinic Specific cardiologist:	Electrocardiography ECG 24-hour Holter 72-hour Holter (j Loop Monitor (select 1 week	2D Echocar 3D Echocar 4D Exercise (Bi 4D Exercise (Bi 4D Exercise (Bi 4D Exercise (Bi 5D Exercise (Bi 5D Exercise (Bi 6D Exercise (Bi 7D Exer	diography (ITE) diography with bubble ageal echocardiogram (cycle) Stress Echocardio e Stress Echocardiograp logy tamibi Res gical Exc Do lium Cardiac pler Cardiac pler Byp dial index with exercise Gl	TEE) ography ohy sting RNA (MUGA) ercise RNA butamine RNA		
REFERRING PHYSICIAN INFORMATION - PLEASE COMPLETE						
Referring Physician: Billing Number:	gnature: ffice Address:	ress: City:				
Phone Number:				Postal Code:		
Copies of reports to:	Date: MM / DD / YYYY					

PLEASE FAX ALL REFERRALS TO CENTRAL TRIAGE: 905-577-8037