Outpatient Cardiology and Diagnostic Testing Referral Form

McMaster University

Hamilton Health Sciences
CARDIAC AND VASCULAR PROGRAM

St. Joseph's Healthcare Hamilton

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

PLEASE SELECT:

☐ **Cardiology Consultation**

PLEASE INDICATE CONSULT URGENCY : ☐ Urgent (<2 weeks) ☐ Elective (2-6 weeks)

☐ **Cardiac Diagnostic Testing**

PLEASE PERFORM CARDIAC TESTING: ☐ On Cardiac Medications ☐ Off cardiac medications

Reason / clinical information (please attach relevant information): _____

CARDIOLOGY CONSULTATION

(Choose below)

☐ 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: _____

CARDIAC DIAGNOSTIC TESTING

Electrocardiography
☐ ECG
☐ 24-hour Holter
☐ 72-hour Holter (patch)
Loop Monitor (select below):
☐ 1 week ☐ 2 weeks
☐ 4-weeks with remote central monitoring

Exercise Testing
☐ Treadmill
☐ Metabolic treadmill
☐ Metabolic bicycle
☐ Resting metabolic study

Cardiac PET
☐ Cardiac perfusion
☐ FDG viability

Echocardiography
☐ 2D Echocardiography (TTE)
☐ 2D Echocardiography with bubble study
☐ Transesophageal echocardiogram (TEE)
☐ Exercise (Bicycle) Stress Echocardiography
☐ Dobutamine Stress Echocardiography

Nuclear Cardiology
☐ Exercise sestamibi
☐ Pharmacological sestamibi
☐ Resting thallium

Peripheral Doppler
☐ Ankle-brachial index
☐ ABI/PVR with exercise
☐ Other: _____

Cardiac MRI
Referral Form Available Online

☐ Resting RNA (MUGA)
☐ Exercise RNA
☐ Dobutamine RNA

Cardiac CT
☐ Coronary CT
☐ TAVI CT
☐ Bypass CT
eGFR (Date):_____.
Contrast Allergy: Y/N / Unknown

REFERRING PHYSICIAN INFORMATION - PLEASE COMPLETE

Referring Physician:	Signature:	
Billing Number:	Office Address:	City:
Phone Number:	Fax Number:	Postal Code:
Copies of reports to:		Date: MM / DD / YYYY

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

Cardiology physicians are available Monday-to-Friday between 8:30am-4:30pm for telephone consultation or urgent requests at 905-577-1414