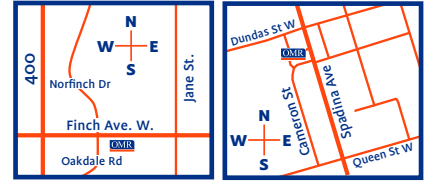




Cardiology and Diagnostics Clinics

2065 Finch Ave. West, Suite 212, Toronto, ON M3N 2V7
260 Spadina Ave., Suite 308, Toronto, ON M5T 2E4

■ Tel: 647-477-6151 ■ Fax: 1-866-692-6954



Patient Name _____

D.O.B _____ F M Weight _____

Patient Phone _____

OHIP# _____ VC _____

Please fax referral to 1-866-692-6954

Appointment Date _____

Time _____

Finch Clinic Spadina Clinic

Please see below for patient instructions

Check if applicable **STAT**

CARDIOLOGY	
<input type="checkbox"/>	12-LEAD ELECTROCARDIOGRAM (REST ECG)
<input type="checkbox"/>	ECHOCARDIOGRAM (COLOUR DOPPLER)
	<i>Please select one of the following indications:</i>
<input type="checkbox"/>	Chest pain suspicious of CAD
<input type="checkbox"/>	Murmur
<input type="checkbox"/>	Congestive heart failure
<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Palpitations / arrhythmias
<input type="checkbox"/>	Syncope
<input type="checkbox"/>	Other _____
<input type="checkbox"/>	STRESS ECHOCARDIOGRAM
	<i>Please select one of the following indications:</i>
<input type="checkbox"/>	Coronary artery disease
<input type="checkbox"/>	Prognosis and risk stratification in patients with established diagnosis
<input type="checkbox"/>	Preoperative risk assessment
<input type="checkbox"/>	Evaluation of cardiac etiology of exertional dyspnea
<input type="checkbox"/>	Evaluation after revascularization
<input type="checkbox"/>	Ischemia location
<input type="checkbox"/>	Evaluation of heart valve stenosis severity
<input type="checkbox"/>	EXERCISE STRESS TEST (GXT)
	<i>Please select one of the following indications:</i>
<input type="checkbox"/>	Evaluation of chest pain/dyspnea
<input type="checkbox"/>	Prognosis and risk stratification in patients with established diagnosis
<input type="checkbox"/>	Assessment of antianginal therapy
<input type="checkbox"/>	Other _____
<input type="checkbox"/>	HOLTER MONITOR
<input type="checkbox"/>	24 Hours
<input type="checkbox"/>	1 Week
<input type="checkbox"/>	48 Hours
<input type="checkbox"/>	2 Weeks
<input type="checkbox"/>	72 Hours
<input type="checkbox"/>	____ Hours / Weeks / Months
<input type="checkbox"/>	24 HR BP Monitor (\$80.00 fee required)
<input type="checkbox"/>	48 HR BP Monitor (\$120.00 fee required)

CARDIOLOGY CONSULTATION	
<input type="checkbox"/>	CONSULTATION REQUESTED
<input type="checkbox"/>	Urgent, first available
<input type="checkbox"/>	Dr. Hani Amad, Cardiologist
<input type="checkbox"/>	Dr. Amar Uxa, Cardiologist
<input type="checkbox"/>	Dr. John Janevski, Cardiologist
<input type="checkbox"/>	Dr. Jennifer Amadio, Cardiologist
<input type="checkbox"/>	Dr. Mosaad Alhussein, Cardiologist
<input type="checkbox"/>	Dr. Ophelia Yeboah, Cardiologist
<input type="checkbox"/>	Dr. Krishnakumar Nair, Electrophysiologist
<input type="checkbox"/>	CONSULT IF TEST RESULT IS POSITIVE / ABNORMAL
PATIENT PREPARATION AND INSTRUCTIONS	
<ol style="list-style-type: none"> A valid health card must be shown at every visit. A signed requisition by a physician is mandatory for all exams. A minimum 24 hours Notice is required for any cancellations. 	
EXERCISE STRESS TEST / STRESS ECHOCARDIOGRAM	
<ul style="list-style-type: none"> Wear soft sole shoes and comfortable clothing. Please bring a list of your current medications. Patients are required to discontinue use of Beta Blocker therapy 48 hours prior to testing if clinically feasible. Please consult your family physician. 	
HOLTER MONITORING	
Please do not put any cream/lotion on your chest. Wear loose comfortable clothing. Bring your current list of medications.	
BLOOD PRESSURE MONITORING	
Please wear blouse/shirt with short or loose fitting sleeves. Bring your current list of medications.	
<i>Languages spoken in the office: English, Arabic, Assyrian, Hindi, Urdu, Punjabi, Filipino and Russian</i>	

CLINICAL INFORMATION

Referring Physician: _____ Print Name _____ Signature _____ Fax #: _____

Copy To: _____ Print Name _____ Fax #: _____