Capital Cardiology
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CAPITAL CARDIOLOGY

Patient's Name: _____ **Referring Physician:**

DOB: _____ _____

Phone Number (H): _____ OHIP billing number:

Phone Number (M): _____ _____

Phone Number (other): _____ Fax number:

Email: _____ _____

OHIP: _____ Signature:

Address: _____

_____ _____

☐ Urgent (<2 week)

☐ Semi Urgent (2-4 wks)

☐ Routine

☐ Chest Pain Referral Clinic (<1 week)

REFERRAL REQUESTED FOR:

☐ Consultation: ☐ 1st available ☐ Specific MD: _____

☐ Cardiac Testing:
- ☐ Persantine Myoview ****NEW**** (Pharmacological Stress Myoview)
- ☐ Exercise Myoview ****NEW****
- ☐ Echocardiogram
- ☐ Exercise Stress Echocardiogram (treadmill)
- ☐ Holter monitor ☐ 72-hr ☐ 14-day
- ☐ Ambulatory Blood pressure monitor: ($100 Not covered by OHIP)

All critical finding on tests will be seen on consult

INDICATION:

☐ Chest pain	☐ Murmur	Other:
☐ Palpitations	☐ Syncope	_____
☐ Shortness of breath	☐ Valve disease	_____
☐ Heart failure	☐ Family history	_____
☐ Coronary artery disease	☐ Abnormal ECG	_____

PAST MEDICAL HISTORY: (Please attach a list of medications, relative notes or tests/labs if applicable):

☐ CHF	☐ Coronary artery Disease	Other:
☐ DM	☐ HTN	_____
☐ Dyslipidemia		_____

For testing instruction please visit our website ***www.capitalcardiology.ca***

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