



Patient's Name:	Referring Physician:	Urgent (<2 week)
DOB:		
Phone Number (H):	OHIP billing number:	Semi Urgent (2-4 wks)
Phone Number (M):		
Phone Number (other):	Fax number:	Routine
Email:		
OHIP:	Signature:	Chest Pain Referral Clinic (<1 week)
Address:		

REFERRAL REQUESTED FOR:					
Consultation:	1st available	Dr. Hafez	Dr. O'Brien	Dr. Rizk	Dr. Psarras
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)				
<i>All critical finding on tests will be seen on consult</i>					

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		