



# York Clinical Cardiology and Metabolism

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Patient First Name \_\_\_\_\_  
Home # \_\_\_\_\_  
Cell # \_\_\_\_\_  
OHIP # \_\_\_\_\_

Last Name \_\_\_\_\_  
DOB (MM/DD/YY) \_\_\_\_\_  
Address \_\_\_\_\_

## CONSULTATION (please provide clinical history below)

With Dr. \_\_\_\_\_ OR  First Available  URGENT

Please forward prior cardiology records, recent blood work, and any other relevant documents.

## TESTING REQUESTED

- |   |   |
|---|---|
| <input type="checkbox"/> Echocardiogram <input type="checkbox"/> with contrast        | <input type="checkbox"/> 24-hour Holter Monitor           |
| <input type="checkbox"/> Treadmill Exercise Tolerance Test                            | <input type="checkbox"/> 48-hour Holter Monitor           |
| <input type="checkbox"/> Stress Echocardiogram <input type="checkbox"/> with contrast | <input type="checkbox"/> 72-hour Holter Monitor           |
| <input type="checkbox"/> 12-lead ECG  | <input type="checkbox"/> 14-day Holter Monitor            |
| <input type="checkbox"/> 24-hour Ambulatory BP Monitor (\$80)                         | <input type="checkbox"/> 14-day Event Loop Recorder (ELR) |

Indication (mandatory) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  PLEASE ARRANGE CONSULTATION IF ABNORMAL

## NUCLEAR IMAGING (arranged offsite)

- Treadmill Stress Perfusion Imaging
- Vasodilator Perfusion Imaging (with Persantine)
- Rest Thallium Viability Study
- Rest MUGA (for EF assessment)

Patient Height \_\_\_\_\_  
Weight \_\_\_\_\_

Indication (mandatory) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## VASCULAR (arranged offsite)

- Bilateral Carotid Duplex Imaging
- Arterial Duplex
  - Upper Extremities (B) (R) (L)
  - Lower Extremities (B) (R) (L)
  - Abdominal Aorta Only
- Venous Duplex
  - Upper Extremities (B) (R) (L)
  - Lower Extremities (B) (R) (L)
- Bilateral Renal Artery Duplex

## CLINICAL HISTORY

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring MD \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

Billing # \_\_\_\_\_  
Physician Signature \_\_\_\_\_