



9401 Jane Street Suite 117, Vaughan, Ontario L6A 4H7
Tel. 289.963.2273 Fax. 905.303.0052
Email: info@yorkcardiology.ca
www.yorkcardiology.ca

Patient First Name _____
Home # _____
Cell # _____
OHIP# _____

Last Name _____
DOB (MM/DD/YY) _____
Address _____

CONSULTATION (please provide clinical history below)

- ☐ With Dr. Weinstock OR ☐ First Available ☐ URGENT
☐ With Dr. Kaplin

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

TESTING REQUESTED

- | | |
|---|---|
| ☐ Echocardiogram ☐ with contrast | ☐ 24-hour Holter Monitor |
| ☐ Treadmill Exercise Tolerance Test | ☐ 48-hour Holter Monitor |
| ☐ Stress Echocardiogram ☐ with contrast | ☐ 72-hour Holter Monitor |
| ☐ 12-lead ECG | ☐ 14-day Holter Monitor |
| ☐ 24-hour Ambulatory BP Monitor (\$80) | ☐ 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)

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 _____