



Simcoe Diabetes Cardio Renal Clinic

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Patient name:		HC#
DOB:	Patient address:	
Pt phone#1:	Family physician:	
Pt phone#2:	Other specialists:	

Referral priority:

- Urgent (<1 month) Non-urgent (1-2 months)

Cardiac Services

Holter - Band (cell phone required)

- 7 days
- 14 days

Consult

Stress Test

Echo - will arrange

<p>Indication for holter:</p> <input type="checkbox"/> R/o atrial fibrillation/flutter <input type="checkbox"/> Known atrial fib/flutter <input type="checkbox"/> Palpitations <input type="checkbox"/> TIA/Stroke <input type="checkbox"/> Chest pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Syncope

Diabetes Cardio-Renal Consult

Brief History:

- T2DM – date of diagnosis: _____
- Coronary artery disease/MI
- Peripheral vascular disease/CVA
- Renal failure/proteinuria
- Peripheral neuropathy
- Amputation
- Severe retinopathy
- History of hypoglycemia

Please send copies of following info:

- Previous consult note
- Current list meds/allergies/intolerances
- Recent lab investigations

Additional comments:

Signature _____

Date _____