



**PATIENT INFORMATION**

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 PHONE #: \_\_\_\_\_ OHIP#: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

**APPOINTMENT**  
 DATE: \_\_\_\_\_  
 TIME: \_\_\_\_\_  
 \* PLEASE ARRIVE 10 MIN. BEFORE YOUR APPT. TIME.  
 \*48 HOURS NOTICE FOR CANCELLATIONS.

**CLINICAL INFORMATION** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**REFERRING PHYSICIAN** \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 TEL/FAX \_\_\_\_\_  
 OHIP BILLING # \_\_\_\_\_  
 SIGNATURE \_\_\_\_\_  
 COPY TO \_\_\_\_\_

**CARDIOLOGY**

12-LEAD ELECTROCARDIOGRAM (Rest ECG)  Bubble Study (assess intra-cardiac shunt)  
 STRESS ECHOCARDIOGRAM (Ischemic Evaluation)  
 CONTRAST ECHOCARDIOGRAM  
 ECHOCARDIOGRAM (Colour doppler) Please select one of the following indications:  
 Chest Pain  Murmur  
 Hypertension  Palpitations/Arrhythmias  
 Syncope  Congestive Heart Failure  
 Other: \_\_\_\_\_  
 Holter Monitoring with 12 Lead ECG  
 24 hrs  48 hrs  72 hrs  Other: \_\_\_\_\_  
 LOOP/Cardiac Event (2 weeks)  24 hr BP Monitor (\$80 cash only- Not covered by OHIP)  
 Tilt Table

**CARDIOLOGY CONSULTATION**

Consultation Requested  URGENT  
 First available appointment  
 Dr. \_\_\_\_\_  
 Consult if test result positive / abnormal