NOBLE MEDICAL AND DIAGNOSTICS

P:905-237-5433 F:905-747-1511

CARDIOLOGY REFERRAL FORM

First name: _____ Last name: _____ DOB: _____(dd/mm/yy)

Health Card: _____ Version Code: _____ Sex: F / M

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Physician: _____ Signature: _____Date:_____

Phone: _____ Fax: _____Billing Number:_____

REQUESTING

- ◯ Cardiology consultation
- ◯ 2D Colour/Doppler Echocardiography
- ◯ Exercise Stress Echocardiogram
- ◯ Holter Monitoring □48 hr □72 hr
- ◯ Exercise Perfusion & Function Scan
- ◯ Coronary Angiogram (pt will be seen first)
- ◯ Cardiology consultation if abnormal testing
- ◯ Loop/Event Recorder □2-week □ 4-week
- ◯ Exercise Stress Test
- ◯ Holter/Loop Hookup at patient's home
- ◯ Pharmacologic Perfusion & Function Scan

REASON FOR REFERRAL

- ◯ Chest Pain
- ◯ Shortness of breath
- ◯ Palpitations
- ◯ Heart Murmur
- ◯ Syncope/ Pre-syncope
- ◯ Hypertension
- ◯ Known/suspected CAD
- ◯ Arrhythmia
- ◯ Abnormal EKG
- ◯ Heart Failure
- ◯ Edema
- ◯ Other_____

TIMING

- ◯ Elective
- ◯ Urgent (within 1 week)
- ◯ Within 2 weeks
- ◯ Other_____

CARDIAC SUBSPECIALTY CONSULTATION (if applicable)

- ◯ Electrophysiology/Arrhythmia
- ◯ Cardiac Imaging
- ◯ Hypertrophic Cardiomyopathy
- ◯ Cardiac Devices/Arrhythmia

History: _____

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