

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

PATIENT INFORMATION (PRINT OR AFFIX LABEL)			
LAST NAME		FIRST NAME	
HEALTH CARD #	VERSION CODE	DATE OF BIRTH (DD/MM/YYYY)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS		CITY	POSTAL CODE
PHONE (HOME)	PHONE (WORK)	PHONE (CELL)	
PREFERRED METHOD OF CONTACT <input type="checkbox"/> PHONE <input type="checkbox"/> EMAIL	EMAIL ADDRESS		
DIAGNOSIS/REASON FOR REFERRAL			
URGENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Abnormal CXR <input type="checkbox"/> Abnormal ECG <input type="checkbox"/> ACS/Post Myocardial Infarct <input type="checkbox"/> Arrhythmia (specify below) <input type="checkbox"/> Atrial Fibrillation – New Onset <input type="checkbox"/> Atrial Fibrillation – Reassess <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Chest Pain <input type="checkbox"/> Conduction Disturbances <input type="checkbox"/> Congenital/Inherited Disease (specify below and provide old reports, if possible)	<input type="checkbox"/> Congestive Heart Failure with Edema <input type="checkbox"/> Congestive Heart Failure without Edema <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Dyspnea/SOBOE <input type="checkbox"/> Endocarditis <input type="checkbox"/> Evaluation of Drug Therapy <input type="checkbox"/> Hypertension <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Murmur <input type="checkbox"/> Pacemaker/ICD assessment <input type="checkbox"/> Palpitations <input type="checkbox"/> Pericardial Disease	<input type="checkbox"/> Post Cardiac Bypass <input type="checkbox"/> Prosthetic Heart Valve (specify position/type/date of implant below, if known) <input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Suspected Structural Heart Disease <input type="checkbox"/> Syncope/Presyncope <input type="checkbox"/> TIA/Stroke/Embolic Event <input type="checkbox"/> Valvular Disease Follow Up (specify below) <input type="checkbox"/> Valvular Regurgitation (specify below) <input type="checkbox"/> Valvular Stenosis (specify below) <input type="checkbox"/> Other (specify below)	
OTHER CLINICAL INFORMATION INCLUDING MEDICATIONS (SPECIFY CONDITIONS, IF POSSIBLE)			
REQUESTED TESTING/SERVICE			
<input type="checkbox"/> HOLTER MONITOR <input type="checkbox"/> 24 HOURS <input type="checkbox"/> 48 HOURS <input type="checkbox"/> 72 HOURS <input type="checkbox"/> 14 DAYS			
REFERRING PHYSICIAN INFORMATION			
NAME (PLEASE PRINT)		BILLING NUMBER	
PHONE		FAX	
COPY TO (PRINT FULL NAME)		COPY TO (FAX)	
SIGNATURE (REFERRING PHYSICIAN)		DATE	

**To book appointment call 519-245-5295 (ext 5531) OR fax requisition to 226-330-0934 and we will contact patient to schedule appointment**  
**NOTE: Please attach all relevant clinical information (past history and current medications) for consultations and stress test referrals**