ULTIMATE DIAGNOSTICS INC.

www.ultimatediagnostics.com

CARDIOLOGY REFERRAL FORM

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

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

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

Address: _____ City: _____ Postal: _____

ATTACH PATIENT STICKER HERE

Referring Physician: _____

Signature: _____ Date: _____

REQUESTING

- ◯ Cardiology Consultation
- ◯ 2D Colour/Doppler Echocardiography
- ◯ Exercise Stress Echocardiogram
- ◯ Exercise Stress Test
- ◯ Cardiology Consultation if Abnormal Testing
- ◯ Holter Monitoring ☐ 48 hr
- ◯ Loop/Event Recorder ☐ 2-week ☐ 4-week

REASON FOR REFERRAL

- ◯ Chest Pain
- ◯ Shortness of breath
- ◯ Palpitations
- ◯ Heart Murmur
- ◯ Heart Failure/LV dysfunction
- ◯ Syncope/ Pre-syncope/ Dizziness
- ◯ Hypertension
- ◯ Known/suspected CAD
- ◯ Arrhythmia
- ◯ Other_____
- ◯ Abnormal EKG
- ◯ Risk assessment
- ◯ Preoperative

TIMING

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

Clinical History: _____

_____

_____

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