bookaclinic

Online Specialist Care. Anywhere.

PATIENT REFERRAL FORM

Fax to: (416) 572-8732
Phone: 905-798-1512
2300 Eglinton Ave West, Mississauga, ON, L5M 2V8

(Please include ALL relevant investigations, imaging reports, and blood work with referral.)

Patient Information

Name:
Address:
Contact Number:
Date of Birth:
Health Card Number:

Referring Physician

Name:
Billing Provider #:
CPSO #:
Office Phone Number:
Office Fax Number:

Clinical Information/Indications:

- Chest pain
- SOB
- Abnormal ECG
- Palpitations/Dizziness
- Rule out CAD:
- Other:

CARDIOLOGY CONSULTATION

☐ Routine
☐ Urgent

CARDIO DIAGNOSTICS TESTS

☐ Graded Exercise Stress Test – Treadmill (GXT)*

*(Please refer to the ACC/AHA 2022 Guideline Update for Exercise Testing for the Indications and Absolute/Relative contraindications to GXT's.)

☐ Echocardiogram ☐ ECG

☐ 48-Hour Holter Monitor **
☐ 72-Hour Holter Monitor**
☐ 14-day Holter**

**(Please refer to the 1999 ACC/AHA guidelines for ambulatory electrocardiography.)

If you require a Cardiology Consultation in addition to the above Cardio Diagnostics tests, please check the appropriate box under "Cardiology Consultation."

Signature of Referring Physician: _____ Date: _____