HEALTHY HEART CENTRE

FAX REQUISITION FORM TO:
1.866.485.1171

TO BOOK AN APPOINTMENT CALL : (416) 286 4442

* If you need to re-schedule your appointment, please call us at least 24 hours in advance so that we can accommodate other patients if necessary.

PATIENT INFORMATION

FIRST NAME : .....

LAST NAME : .....

OHIP NO : .....

D.O.B. : .....

ADDRESS : .....

TEL NO. : .....

REFERRING PHYSICIAN

REFERRING MD : .....

MD SIGNATURE : .....

BILLING NO : .....

ADDRESS : .....

FAX NO : .....

☐ **URGENT**

- ☐ CARDIOLOGY CONSULTATION
- ☐ INTERNAL MEDICINE CONSULTATION
- ☐ ECHOCARDIOGRAPHY
- ☐ STRESS ECHO
- ☐ STRESS TEST
- ☐ RESTING ECG
- ☐ HOLTER ❍48 HRS ❍72 HRS
- ☐ PULMONARY FUNCTION TEST
- ☐ CHF / HTN (ECG / ECHO)
- ☐ CHEST PAIN / CAD (ECHO / ECG / STRESS ECHO)
- ☐ ARRHYTHMIA (ECG / ECHO / 72 HRS HOLTER)
- ☐ AMBULATORY BLOOD PRESSURE MONITOR ($65)
- ☐ CONTINOUS RECORDERS: ❍1 WEEK ❍2 WEEK
- ☐ NUCELAR CARDIOLOGY: _____
- ☐ LOOP / CARDIAC EVENT MONITOR
- ☐ IF TEST IS ABNORMAL PLEASE ARRANGE FOR A CONSULTATION

PRE OR POST EVALUATION

- ☐ PCI
- ☐ DEVICE PLACEMENT
- ☐ EP PROCEDURES
- ☐ SURGERY

OTHER:_____

REASON FOR TEST

- ☐ PALPITATION
- ☐ CHEST PAIN
- ☐ SOB
- ☐ ABNORMAL ECG
- ☐ CHF
- ☐ ARRHYTHMIA
- ☐ STROKE / TIA
- ☐ PAD
- ☐ MI
- ☐ VALVULAR DISEASE
- ☐ HEART MURMUR
- ☐ PERIPHERAL EDEMA
- ☐ OTHER: .....
- ☐ HYPOTENSION
- ☐ HTN
- ☐ SYNCOPE / DIZZINESS
- ☐ ENDOCARDITIS
- ☐ AORTIC DISSECTION
- ☐ PULMONARY HYPERTENSION

MODERATE TO HIGH RISK PROGRAM

- ☐ AGE
- ☐ FAMILY HISTORY
- ☐ ETHNICITY
- ☐ DIABETES MELLITUS
- ☐ HYPERTENSION
- ☐ SMOKING HISTORY
- ☐ OBESITY
- ☐ SEDENTERY LIFESTYLE
- ☐ HIGH STRESS
- ☐ DYSLIPIDEMIA
- ☐ POOR DIET
- ☐ METABOLIC SYNDROME

* Please bring with you this requisition form, your health card and your list of medications. Thank you for your cooperation.

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