CARDIOLOGY REQUISITION FORM

111 SIMCOE STREET NORTH, UNIT 100
OSHAWA, ON. L1G 4S4
TEL: 742-333-1256 | FAX: 289-731-2081
EMAIL: ADMIN@SIMCOECARDIOLOGY.COM

☐ **URGENT** ☐ **ROUTINE**

Date of Referral:

PATIENT INFORMATION:

Name: _____	Date of Birth (MM/DD/YYYY): _____ Gender: ____
Address: _____	OHIP Number: _____
Phone: _____	Alternate Phone: _____
Email: _____	

CARDIOLOGY CONSULTATION:

☐ **CONSULT** ☐ **CONSULT, IF TEST RESULTS IS POSITIVE/ABNORMAL**

CARDIAC DIAGNOSTIC TESTING:

ECHOCARDIOGRAPHY:
- ☐ 2D Echocardiography

EXERCISE TESTING (TREADMILL):
- ☐ Stress Test

ELECTROCARDIOGRAPHY:
- ☐ Holter - 24-hour
- ☐ Holter - 72-hour
- ☐ Holter - 7 or 14 Days
- ☐ ECG

REASON FOR REFERRAL:

SYMPTOMS:
- ☐ Chest Pain
- ☐ Dyspnea
- ☐ Edema
- ☐ Palpitations
- ☐ Presyncope
- ☐ Syncope
- ☐ Fatigue

CLINICAL DIAGNOSES AND HISTORY:
- ☐ Atrial Fibrillation/Flutter
- ☐ Ischemic Heart Disease
- ☐ Myocardial Infarction
- ☐ Heart failure
- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Diabetes Mellitus
- ☐ Abnormal Resting ECG
- ☐ Abnormal Stress Test
- ☐ Abnormal Coronary CT
- ☐ Cardiac masses/thrombus
- ☐ Stroke/TIA
- ☐ Endocarditis
- ☐ Myocarditis
- ☐ Pericarditis
- ☐ Rheumatic Fever
- ☐ CABG /Bypass
- ☐ Angioplasty /Stent
- ☐ Pacemaker or ICD/CRT
- ☐ Cardiomyopathy
- ☐ Valvular heart disease
- ☐ Heart murmur NYD
- ☐ Surgery clearance

Other: _____

_____

_____

Referring Physician: _____ Billing Number: _____

Address: _____ Tel: _____ Fax Number: _____

Completed forms are to be returned via fax: 289-731-2081 or email: admin@simcoecardiology.com.
Our office will contact the patient directly to schedule an appointment (please attach any relevant/current reports).