

Request for diagnostic study

- echocardiogram
- 24/48 hour holter
- ECG
- stress test
 - consult if positive
- BP monitor (\$60)

Request for consult

Patient name:

DOB:

Phone number:

Referring physician name and billing #:

Date:

REASON FOR REFERRAL

- chest pain
- dyspnea
- palpitations
- syncope
- hypertension
 - with MAU or reduced GFR
 - with diabetes
- CAD screen in diabetic patient
- stroke/TIA
- CHF
- atrial fibrillation
- other arrhythmia
- murmur/valve disease
- abnormal ECG
- other (please specify)

ESTIMATED URGENCY

- URGENT (to be seen within 1 week)
- ELECTIVE (can wait >1 week)

MEDICATIONS

Please fax completed form to 905 597 3726

APPOINTMENT DATE & TIME (to be completed by office staff):