

PATIENT INFORMATION *Please complete all of this section*

Name _____ D.O.B. _____ Cell _____ Phone _____
 Address _____ City _____ Postal Code _____
 Health Card _____ Version Code _____ Gender _____ Email _____

<u>Reason(s) for Referral:</u>	Yes	No	<u>Existing Condition(s):</u>	Yes	No	<u>Current Medication(s):</u>	Yes	No
Is ECG attached?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Beta-Blocker (enter name)	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal ECG	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
LBBB	<input type="checkbox"/>	<input type="checkbox"/>	Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	Ca Channel Blocker	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fib	<input type="checkbox"/>	<input type="checkbox"/>	PVD	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Chest pain/discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Carotid Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	Other Meds	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Ischemic Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		
SOB @rest OE	<input type="checkbox"/>	<input type="checkbox"/>	Previous MI _____	<input type="checkbox"/>	<input type="checkbox"/>	Additional Indication(s) / Info		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Previous PCI	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Routine Screening	<input type="checkbox"/>	<input type="checkbox"/>	Previous CABG _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Family history of ASHD	<input type="checkbox"/>	<input type="checkbox"/>	Smoker (enter # yrs) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Syncope	<input type="checkbox"/>	<input type="checkbox"/>	Ex-smoker	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Pre-op (Sx date _____)	<input type="checkbox"/>	<input type="checkbox"/>	Obese (weight: _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Valvular Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Post PCI (Date _____)	<input type="checkbox"/>	<input type="checkbox"/>						
Renal disease	<input type="checkbox"/>	<input type="checkbox"/>						
Other _____								

1. **CONSULT** with DR. _____ *pls check box* **Urgent**

Send (fax, mail or cc) all pertinent Hx, reports, tests and lab results prior to appointment.

Diagnostics

pls check box **Urgent**

2. **ECHOCARDIOGRAPHY**

3. **a) Routine Cardiac Stress** -walking on treadmill
 b) Stress Echocardiography - pedalling recumbant bicycle
 c) Dobutamine Stress Echo - for patients unable to exercise (walk or pedal), IV meds simulate exercise

(Please review patient preparation on reverse or website for further information.)

4. **HOLTER MONITOR** MONITOR FOR 24 Hours 48 Hours 72 Hours to 13 Days 14 to 30 Days

5. **AMBULATORY BLOOD PRESSURE MONITOR (ABPM)** *(Not an OHIP benefit - Charge applies)*

6. **CAROTID INTIMA MEDIAL THICKNESS (IMT)** *(Nm an OHIP benefit - Charge applies)*

(Any abnormal test results the attending Doctor may book a consultation at their discretion.)

Referred by _____ Billing# _____

Signature _____



PATIENT PREPARATION

- Shower prior to all testing but DO NOT apply lotion, powder or perfume.
- Bring Health Card to ALL appointments.
- Bring ALL medications in original bottle to any stress test and consult appt.
- Please provide 48 hours notice for cancellation, otherwise you will be billed.

CONSULTATION APPOINTMENT

CALL office one week prior to confirm appointment.

ECHOCARDIOGRAPHY

No preparation required. This is an ultrasound examination of your heart. *Duration: 45mins*

STRESS TESTING

- Routine Cardiac Stress - *Duration: 30 mins.*
- Stress Echocardiography - *Duration: 45 mins.*

Wear comfortable shoes, pants or shorts and top as you will be exercising. Bring ALL medications and a medium sized towel.

No food or drink 2 hours prior to test.

No smoking, caffeine or alcohol 4 hours prior.

STOP ANY BETA BLOCKER MEDICATION 48 HOURS PRIOR TO TEST UNLESS INSTRUCTED OTHERWISE. CHECK WITH PHYSICIAN REGARDING DIABETIC MEDICATION.

- Dobutamine Stress Echocardiography - *Duration: 1 hour*

An intravenous will be used to administer medications to simulate exercise. Bring ALL medications.

No food, drink, alcohol or smoking 4 hours prior to test.

No caffeine products (incl. decaff drinks) 24 hours prior to test.

STOP ANY BETA BLOCKER MEDICATION 48 HOURS PRIOR TO TEST UNLESS INSTRUCTED OTHERWISE. CHECK WITH PHYSICIAN REGARDING DIABETIC MEDICATION.

HOLTER MONITOR/LOOP-EVENT RECORDER

Wear loose fitting blouse or shirt with button-up front. Electrodes and wires will be placed on chest for 24 or 48 hours.

DURING THE MONITORING PERIOD DO NOT IMMERSE ELECTRODES, WIRES OR MONITOR IN WATER.

(NO FULL BATH, SHOWER OR SWIMMING)

AMBULATORY B.P. MONITOR

Wear loose fitting blouse or shirt. Charge applies. Cash, debit or credit card accepted.

Duration: 24 hours

CAROTID IMT

No preparation required. Charge applies. Cash, debit or credit card accepted.

Duration: 15 mins.

