NEW CARDIOLOGY REFERRAL

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Patient Name: _____ Date: _____

Sex ❒ M ❒ F DOB: _____ Patient Phone Number: _____

Referral Type: ❒ **URGENT (within TWO weeks)** ❒ **ELECTIVE**

Reason for Referral: ❒Chest Pain ❒SOB ❒Arrhythmia ❒Abnormal ECG ❒Primary Prevention
❒South Asian Cardiovascular Risk Assessment Clinic ❒ Other: _____

Consultation Request & Diagnostic Testing as Indicated: ❒
Diagnostic Tests can be ordered without a Consultation

Clinical Information/ Past Medical History/ Medications/ Labs
PLEASE ATTACH PRIOR CARDIAC REPORTS, ECG'S, CXR and RECENT BLOODWORK ALONG WITH REFERRAL

Diagnostic Test(s):

❒ Exercise Stress Test ❒ Exercise Cardiolite ❒ Persantine Cardiolite
❒ 2D-Echocardiogram ❒ Stress Echocardiogram ❒ Holter Monitor ❒ 24 hr ❒ 48 hr
❒ Loop Monitor (14 days) ❒ Ambulatory BP Monitor ($50.00 – to be paid by patient)

Referring Physician: _____ **Physician Signature:** _____

Billing Number: _____ **Tel:** _____ **Fax:** _____

Toronto East General Hospital
Sunnybrook Health Sciences Centre