



CARDIOLOGY REQUISITION FORM

Please select the location

☐ CONCORD ☐ KITCHENER ☐ HAMILTON ☐ ST CATHARINES

TO BOOK AN APPOINTMENT CALL (905) 667-5504

PATIENT INFORMATION

FIRST NAME: _____

LAST NAME: _____

HEALTH CARD NO.: _____

DOB: _____ GENDER: _____

ADDRESS: _____

PHONE: _____

EMAIL: _____

PHARMACY: _____

REFERRING PHYSICIAN

REFERRING MD: _____

MD SIGNATURE: _____

BILLING NO.: _____

FAX NO.: _____

ADDRESS: _____

REFERRAL DATE: _____

PROCEDURES

- ☐ CARDIOLOGY CONSULTATION
☐ ADULT ECHOCARDIOGRAM
☐ HOLTER MONITORING
72 hrs / ONE WEEK / TWO WEEKS

- ☐ ECG
☐ TREADMILL STRESS TEST
☐ STRESS ECHO
☐ 24 HOURS AMBULATORY BLOOD
PRESSURE MONITORING
(NOT COVERED BY OHIP)

☐ **URGENT**

☐ IF TEST IS ABNORMAL:
PLEASE ARRANGE FOR A
CONSULTATION

REASON FOR TEST

- ☐ PALPITATION
☐ CHEST PAIN
☐ SOB
☐ ABNORMAL ECG
☐ DIZZINESS
☐ HYPERTENSION
☐ R/O CAD
☐ OTHER PLEASE FILL THE BOX

HISTORY/CLINICAL INFORMATION:

CARDIOVASCULAR RISK REDUCTION PROGRAM

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

FAX THE COMPLETED FORM TO (905) 667-5509
HEARTWELL CARDIOLOGY WILL CONTACT THE PATIENT TO BOOK AN APPOINTMENT
WWW.HEARTWELLCARDIOLOGY.CA