



Cardiac Requestion Form

PATIENT INFORMATION

Patient Name:
(Last, First)

HCN:

DOB:

Address:
City:
Postal code:

Gender: M F

Referring Physician:

Telephone:

CARDIAC TESTING

ELECTROPHYSIOLOGY TESTING

Holter Monitoring ECG
 48 HR 12-Lead ECG
 72 HR

GENERAL CARDIOLOGY TESTING

2D Echocardiogram
 Exercise Stress Test
 Stress Echo
 Ambulatory Blood Pressure
Monitoring (not OHIP covered
\$60)
 Spirometry

Clinical Information:

Please indicate if you would like us to arrange a cardiac consultation in the event of an abnormal result.

CARDIAC CONSULTATION

Dr. A. Arrazaghi *Urgent Referral*

Patient History:

Clinical Information:

Chest Pain/Palpitations Arrhythmias
 Heart Failure CAD/Valvular Disease

REFERRING PHYSICIAN INFORMATION

Referring Physician:

Address:

MD Billing #:

Phone:

Signature: _____

Fax #:

Date: _____

**Please send all completed requisitions to wishingwell@sanovahealth.ca
or fax to: +1 647-948-1663**