*Please attach any patient clinical documents, notes, testing etc.

Wishing Well Cardiac Clinic By Sanova Health
12637 Tenth Line unit 105, Whitchurch-Stouffville,
ON L4A 2X5
TEL: 647-783-7676
FAX: +1 647-948-1663

Cardiac Requestion Form

PATIENT INFORMATION

Patient Name:
(Last, First)

Address:
City:
Postal code:

Telephone:

HCN:

DOB:

Gender: M F

Referring Physician:

CARDIAC TESTING

ELECTROPHYSIOLOGY TESTING

Holter Monitoring
- 48 HR
- 72 HR

ECG
- 12-Lead ECG

Clinical Information:

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

GENERAL CARDIOLOGY TESTING

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

CARDIAC CONSULTATION

Cardiac Consult ☐ *Urgent Referral*

Clinical Information:

Patient History:
- Chest Pain/Palpitations
- Arrhythmias
- Heart Failure
- CAD/Valvular Disease

REFERRING PHYSICIAN INFORMATION

Referring Physician:

MD Billing #:

Address:

Phone:

Fax #:

Signature: _____

Date: _____

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