REFERRAL / REQUISITION FORM

Chatham Cardiac Care
545 Grand Ave E, Chatham, ON N7L 3Z3
Tel: (519) 397-1790 | Fax: (519) 397-1791
chathamcardiac@gmail.com | chathamcardiaccare.com

PATIENT INFORMATION

LAST NAME _____ DATE _____ SEX _____

FIRST NAME _____ PHONE _____

DATE OF BIRTH _____ WORK PHONE _____

HEALTH CARD # _____ EMERGENCY # _____

ADDRESS _____

REFERRING PHYSICIAN

NAME _____ TELEPHONE # _____

ADDRESS _____ FAX # _____

SIGNATURE _____ BILLING # _____

REASON FOR REFERRAL

- ☐ Pre-op Consultation
- ☐ Cardiac Consultation
- ☐ Diagnostic Testing
- ☐ Chest Pain
- ☐ Palpitation
- ☐ Heart Murmur
- ☐ Dizziness
- ☐ Claudication
- ☐ Diabetes
- ☐ Dyslipidemia
- ☐ Syncope
- ☐ High Blood Pressure
- ☐ Shortness of Breath
- ☐ CHF
- ☐ CAD / MI
- ☐ Thoracic Aortic Disease
- ☐ Cardiovascular Screening
- ☐ Hypertension / TIA / Stroke
- ☐ Prosthetic Heart Valve
- ☐ Arrhythmias

PRIORITY

- ☐ Standard
- ☐ Semi-urgent
- ☐ Urgent *Please Call

DIAGNOSTICS

- ☐ Echocardiogram
- ☐ EKG / ECG
- ☐ Holter / Loop Monitor
- ☐ Stress Echocardiogram
- ☐ Exercise Stress Test
- ☐ ABPM
- ☐ ABI (Ankle-Brachial Index)
- ☐ Tilt Table Test
- ☐ Pediatric Echocardiogram (8+)

Holter / Loop duration: ☐ 24 Hours ☐ 48 Hours ☐ 72 Hours ☐ 2 Weeks

Please provide all pertinent information and a list of the patient's current medications.