

Cardiology Clinic Referral Form

1235 Wilson Ave., Toronto ON M3M 0B2 Main Floor - Portal B
 Tel: (416) 242-1000 ext. 47146 Fax: (416) 242-1067

Referral Date (dd/mm/yyyy): ____ / ____ / ____ Referring Physician: _____ Physician Signature: _____ Copies to: _____	Patient ID/Label Patient Last Name: _____ Patient First Name: _____ Date of Birth (dd/mm/yyyy): ____ / ____ / ____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other Tel: (____) ____ - ____
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Request for Cardiology Consult

	Physician	Phone	Fax
<input type="checkbox"/>	Dr. Allan	416-242-1000 ext. 47115	1-855-720-1223
<input type="checkbox"/>	Dr. Bauer	416-245-1150	416-245-1166
<input type="checkbox"/>	Dr. Choudhry	905-595-5505	1-855-716-8821
<input type="checkbox"/>	Dr. Klug	416-849-2313	416-849-2314
<input type="checkbox"/>	Dr. Ng	416-242-1000 ext. 47119	1-855-720-1223
<input type="checkbox"/>	Dr. Szmisko	416-242-1000 ext. 47114	1-855-720-1223
<input type="checkbox"/>	Dr. Tiong	416-242-1000 ext. 47104	1-855-720-1223
<input type="checkbox"/>	Dr. Vozoris	416-242-1000 ext. 47103	1-855-720-1223
<input type="checkbox"/>	Dr. Yao	416-241-1119	416- 241-2623
<input type="checkbox"/>	Dr. Zupnik	416-747-9839	416- 747-7105
<input type="checkbox"/>	Dr. Nadeem	416-242-1000 ext . 47161	416-264-5645
<input type="checkbox"/>	No preference	416-242-1000 ext. 47141	416-242-1067

- Elective Consult
 Urgent Consult

Reason for Consult:

Please remind patient to bring their medications to their appointment

Cardiology Diagnostic Services:

- Transthoracic Echo (TTE)
- Dobutamine Stress Echo
- Exercise Stress Echo
- Contrast Enhanced Echo (Definity)
- Saline Contrast Echo (Bubble)
- Paediatric Echo

- ECG
- Exercise Treadmill Test
- Exercise Nuclear Stress Test Nuclear Stress - Pharmacologic
- Holter Study - specify: 24-hour 48-hour 14-day Cardiostat
- Pacemaker/ICD Check - specify: Single Chamber Dual Chamber
- Ambulatory Blood Pressure Monitor (\$70 charge applies)

Reason/Clinical Indication for Echo:

- Trans-esophageal Echo (TEE) -
Note: requires Cardiology Consult

Patient Appointment Times:

Test: _____ Date (dd/mm/yyyy): ____ / ____ / ____ Time: _____

Test: _____ Date (dd/mm/yyyy): ____ / ____ / ____ Time: _____

Test: _____ Date (dd/mm/yyyy): ____ / ____ / ____ Time: _____

- The Cardiology Clinic has communicated these dates/times with the patient/family.
- The Cardiology Clinic has NOT been able to communicate the dates and times with the patient/family. A letter has been sent to the patient and we request your assistance in communicating the testing dates and times.