Cardiology and Diagnostic Testing Referral Form

☐ **Brampton**
10 Cottrelle Blvd
Unit 205
Brampton, ON
L6S 0E2

☐ **Bolton**
196 McEwan Dr East
Unit 10
Bolton, ON
L7E 4E5

☐ **Etobicoke**
135 Queens Plate
Unit 340
Etobicoke, ON
M9W 6V1

Phone 905-497-7747
Fax 905-497-7748

Patient Information – Please complete

Patient name: _____
Address: _____
Phone number: _____
Date of birth: _____
Health card: _____

REASON FOR REFERRAL – PLEASE COMPLETE

PLEASE SELECT ☐ Cardiology Consultation

PLEASE INDICATE CONSULT URGENCY: ☐ Urgent (< 2weeks) ☐ Elective (2-6 weeks)

☐ Cardiac Diagnostic Testing

Reason /clinical information (please attach relevant information):

_____

_____

Cardiology Consultation

☐ **First Available Cardiologist**
☐ Dr. Marc Allard
☐ Dr. Karan Bami
☐ Dr. David Borts
☐ Dr. Sachin Chopra
☐ Dr. Saeed Darvish-Kazem
☐ Dr. Hassan Masoom
☐ Dr. Christopher Reid
☐ Dr. Jann Patrick Ong
☐ Dr. Sikander Texiwala

Cardiac Diagnostic Testing

Electrocardiography
☐ 12-lead ECG
☐ 48-hour Holter
☐ 72-hour Holter
☐ 2-week Holter monitor

Echocardiography
☐ 2D Echocardiography (TTE)
☐ 2D Echocardiography with Bubble Study
☐ Stress (Treadmill) Echocardiography

Exercise Testing
☐ Exercise (Treadmill) Stress Test

Blood Pressure Monitoring
☐ 24-hour Ambulatory Blood Pressure Monitor ($70)

Referring Physician Information – PLEASE COMPLETE		
Referring Physician:	Signature:	Billing number:
Office Address:	City:	Postal Code:
Phone number:	Fax Number:	Date (DD/MM/YYYY):
Copies of report to:		

Please fax all referrals to central triage at 905-497-7748
We accept electronic referrals via Oceans eReferral Network