



Scarborough Diagnostic Center Cardiac Lab

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FREE PARKING

Cardiology Diagnostics / Referral / Consultation Form

Patient Name: _____ Health Card Number: _____

Birth Date: _____ Age: _____ Sex: _____ 1. Please complete form and fax

Address: _____ 2. See back page for patient instructions

Phone Number: _____ Referring Physician: _____

CARDIOLOGY

- | | | |
|---|---|--|
| <input type="checkbox"/> ECG | <input type="checkbox"/> (Loop Recording 14 days) | <input type="checkbox"/> 2D - Echocardiogram |
| <input type="checkbox"/> Ambulatory BP Monitoring | <input type="checkbox"/> Angiogram | <input type="checkbox"/> Contrast Echocardiography |
| <input type="checkbox"/> Holter Monitoring <input type="checkbox"/> 24H <input type="checkbox"/> 48H <input type="checkbox"/> 72H | <input type="checkbox"/> TEE | <input type="checkbox"/> Exercise Stress Test |
| <input type="checkbox"/> Event Monitoring | <input type="checkbox"/> Cardiac Path | <input type="checkbox"/> Stress Echocardiography |
| | | <input type="checkbox"/> Cardiology Consultation |

Reason for referral: _____

Note: Please forward previous ECGs, Chest X-rays, blood work and cardiac assessments if available.

Other Tests eg. Nuclear, TEE, Cardiac Path etc. will be arranged if needed.

CLINICAL INFORMATION

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> CHT | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitation |
| <input type="checkbox"/> R/O White coat HTN | <input type="checkbox"/> Stroke | <input type="checkbox"/> Chest Discomfort | <input type="checkbox"/> Abnormal ECG |
| <input type="checkbox"/> LVH | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart defect | <input type="checkbox"/> Smoker | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Emphysema /COPD | <input type="checkbox"/> Overweight / Obesity | <input type="checkbox"/> Leg Swelling |
| <input type="checkbox"/> R/O CAD (IHD) | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pre-Syncope | <input type="checkbox"/> Family history of: |
| <input type="checkbox"/> CAD | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Syncope | |
| <input type="checkbox"/> IHD | <input type="checkbox"/> Rhythm Assessment | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Post MI/CABG/PTCA | <input type="checkbox"/> Pre-op | <input type="checkbox"/> Light Headedness | <input type="checkbox"/> Other: |

Please bring all list of medication if available.

Physician Signature: _____

PATIENT INSTRUCTIONS / INFORMATION

ECG - Based on measurement of the electrical activity of the heart. Duration: around 15 minutes.

Echocardiography - Based on the use of ultrasound waves to study the heart. Duration: around 30 minutes.

Exercise Stress Test - Involves walking and / or running on a treadmill. Please wear comfortable shoes. For Women: Please wear a bra and 2-piece outfit for your convenience (don't wear a dress). Don't take coffee or tea prior to the test. Have a light meal before the test. If you are taking Beta Blockers and / or Calcium Channel Blockers, please consult your doctor regarding stopping the medication. Duration: Up to 60 minutes.

Stress Echo - The same as exercise stress test with the addition of echocardiography, done before and after the stress test. Duration: up to 60 minutes.

Please arrive at least 10 minutes before your appointment. Please bring interpreter / translator with you to the appointment if you cannot communicate / understand English. Cancellation / Re-booking: please note that 24 H notice is required for cancellation of your appointment. Please call no later than 3pm the day before the appointment for rescheduling. We are striving to ensure that patients have their appointments on time, however, you might be requested to wait longer than anticipated.

