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Request for Cardiology Consult and/or Diagnostics

Please complete form and fax with relevant documentation to 1-888-744-5841.

Referring MD: _____ Billing #(if never referred before): _____

Phone number: _____ Fax number: _____

Address: _____
Street Town/City Postal Code

Patient Name: _____
Surname First Name

Address: _____
Street Town/City Postal Code

DOB: _____ Sex: _____ Phone # (Res): _____ (Bus): _____

Health Card # & Version Code: _____

Cardiology consultation

Reason for Referral: _____

Medications: _____

Indication for the test

Echo Doppler _____

Contrast Echocardiogram _____

Stress Echocardiogram _____

Exercise Stress Test _____

Holter Monitor 24 hr 72 Hr
 48 Hr 14 Day _____

Electrocardiogram _____

Date of Request: _____

MD Signature: _____