



- Bring appropriate exercise clothing, running shoes, water bottle, and a towel.
- Eat a light breakfast or lunch.
- Bring your medications with you.
- You have been advised by your physician to:
 - Continue all medications
 - Hold the following medication(s) before the test:
 _____ for _____ day(s)
 _____ for _____ day(s)

Patient: _____

Information: _____

<p>Cardiology Consultation</p> <p><input type="checkbox"/> Dr. Roland Sabbagh <input type="checkbox"/> Dr. Preeti Anand <input type="checkbox"/> First available Cardio/Internist</p> <p>Cardiovascular Internist (Hypertension / CKD / Diabetes)</p> <p><input type="checkbox"/> Dr. Carolyn Tharson</p> <p>Respirology Consultation</p> <p><input type="checkbox"/> Dr. Mathieu Saint-Pierre</p> <p><input type="checkbox"/> URGENT</p>	<p>Indication</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Syncope <input type="checkbox"/> CV risk assessment</p> <p><input type="checkbox"/> Dyspnea <input type="checkbox"/> Cough <input type="checkbox"/> Abnormal imaging</p> <p><input type="checkbox"/> Other: _____</p>	<p>Testing and Therapeutic Services</p> <p><input type="checkbox"/> ECG <input type="checkbox"/> Exercise Treadmill test <input type="checkbox"/> Exercise Stress Echocardiogram <input type="checkbox"/> Pharmacologic Stress Echo <input type="checkbox"/> Echocardiogram</p> <p><input type="checkbox"/> 48 hour Holter <input type="checkbox"/> 72 hour Holter <input type="checkbox"/> 1 week Holter <input type="checkbox"/> 2 week Holter <input type="checkbox"/> Ambulatory BP Monitor ¹</p> <p><input type="checkbox"/> Spirometry</p> <p><input type="checkbox"/> Cardiac Rehabilitation ² <input type="checkbox"/> Pulmonary Rehabilitation ²</p>								
	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center;">Medications</td> <td style="text-align: center;">Held ?</td> </tr> <tr> <td>Digoxin <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>BB <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>CCB <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Medications	Held ?	Digoxin <input type="checkbox"/>	<input type="checkbox"/>	BB <input type="checkbox"/>	<input type="checkbox"/>	CCB <input type="checkbox"/>	<input type="checkbox"/>	
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BB <input type="checkbox"/>	<input type="checkbox"/>									
CCB <input type="checkbox"/>	<input type="checkbox"/>									

¹ Note that the ABPM is not covered by OHIP
² A consultation will be performed prior to rehabilitation. The rehabilitation services at this location are not covered by OHIP.

Referring MD: _____

Provider Number: _____

CC: _____

Date: _____

Signature: _____

