

Mississauga: 640 Eglinton Ave W
Ottawa: 1935 Bank Stree
Sudbury: 9-2140 Regent St.
Timmins: 117-38 Pine St. N.
Cochrane: 4-233 Eighth St.
Iroquois Falls: 58A Anson Drive.
North Bay: 304-1950 Algonquin Av
Temiskaming Shore: 240 Shepherd



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Phone: +1(289) 499-1022
 Fax: +1(905) 917-4165
info@carecardiology.ca

Request For Cardiac Examination

Patient Information (Affix Label if Available)					
Full Name:			Gender:	Height:	Weight:
Address:	Street # & Name:		City:	Postal Code:	
Health Card #:			Cell Phone		
Date Of Birth:	dd/mm/yy:	Age:	Family Physician:		
Clinical Indication					
Clinical Hx:-					
☐ Chest Pain	☐ SOB	☐ Palpitation	☐ Syncope	☐ Murmur	☐ CVA/TIA
☐ CAD	☐ CHF	☐ Arrythmias	☐ LL swelling	☐ Others:	
Examination(s) Requested					
☐ Echocardiography (regular comprehensive TTE). Add:- ☐ Bubble Study ☐ Strain Study					
☐ Contrast Echocardiography.					
☐ Pediatric Echo					
☐ Exercise Stress Echocardiography (SE)					
☐ Ischemic Heart Disease Protocol					
☐ Diastolic Dysfunction Protocol					
☐ Cardiomyopathies Protocol					
☐ Native Valve Disease Protocol					
☐ Exercise Stress ECG (GXT)					
☐ Rest 12-Lead ECG.					
☐ Holter Monitoring: ☐ 72 hrs ☐ 1 week ☐ 2 Weeks ☐ Others:					
☐ In-Clinic / Walk-In (9 am – 12 pm and 1 pm to 4 pm)					
☐ By-Mail (No extra fee)					
☐ At-Home (No extra fee)					
☐ BP Monitoring (24 Hours) (Not insured by OHIP but FREE if requested by patient)					
☐ Cardiology Consultation					
☐ Urgent					
Referring Physician Information (Stamp Label if Available)					
Referring Physician:			Tel:		
Physician's Signature:			Fax:		
			Copy to:		
Billing Provider #:			Note:		
Date: dd/mm/yy:					