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☐ Urgent Request.

Note: This form can be
 Downloaded from:
www.ocaheart.ca

Request For Cardiac Examination

Patient Information (Affix Label if Available)					
Full Name:					
Address:		Street # & Name:		City:	Postal Code:
Cell Phone:		Alt. Phone:			
Date Of Birth:	dd/mm/yy:	Age:	Gender:	Height:	Weight:
Health Card #:		Family Physician:			
Clinical Indication					
Clinical Hx:-					
☐ Chest Pain	☐ Coronary Artery Disease	☐ Cardiomyopathy:			
☐ Shortness Of Breath	☐ Congestive Heart Failure	☐ Congenital Heart Disease:			
☐ Palpitation	☐ Arrhythmias	☐ Valve Replacement:			
☐ Syncope	☐ CVA/TIA	☐ Pre-Operative:			
☐ Murmur	☐ Valvular Heart Disease	☐ Chemotherapy:			
☐ LL swelling	☐ Pulmonary Hypertension	☐ Follow up of:			
Examination(s) Requested				Comments	
☐ Echocardiography (regular comprehensive TTE). Add:-					
☐ Bubble Study.					
☐ Strain Analysis.					
☐ Contrast Echocardiography.					
☐ Exercise Stress Echocardiography.					
☐ Pediatric Echocardiography.					
☐ Rest 12-Lead ECG.					
☐ Exercise Stress ECG.					
☐ Holter Monitoring: ☐ 72 hrs ☐ 1 week ☐ 2 Weeks					
☐ By-Mail (Xpresspost)					
☐ Walk-In In-Clinic					
☐ BP Monitoring (24 Hours ABPM) (Not insured by OHIP)					
☐ Cardiology Consultation (Adult)					
☐ Action on significantly abnormal.					
☐ Urgent					
☐ Other:-					
Referring Physician Information (Stamp Label if Available)					
Referring Physician:			Tel:		
Physician's Signature:			Fax:		
			Copy to:		
Billing Provider #:			Note:		
Date: dd/mm/yy:					