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“Ottawa Cardiology Centre”

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:					
<input type="radio"/> Chest Pain	<input type="radio"/> SOB	<input type="radio"/> Palpitation	<input type="radio"/> Syncope	<input type="radio"/> Murmur	<input type="radio"/> CVA/TIA
<input type="radio"/> CAD	<input type="radio"/> CHF	<input type="radio"/> Arrythmias	<input type="radio"/> LL swelling	<input type="radio"/> Others:	
Examination(s) Requested					
<input type="radio"/> Echocardiography (regular comprehensive TTE)					
<input type="radio"/> Contrast Echocardiography.					
<input type="radio"/> Bubble study Echocardiography.					
<input type="radio"/> Pediatric Echo (7 years and older)					
<input type="radio"/> Exercise Stress Echocardiography (SE)					
<input type="radio"/> Ischemic Heart Disease Protocol					
<input type="radio"/> Diastolic Dysfunction Protocol					
<input type="radio"/> Cardiomyopathies Protocol					
<input type="radio"/> Native Valve Disease Protocol					
<input type="radio"/> Exercise Stress ECG + LV wall motion Echo assessment before & immediately after Exercise (Stress Echocardiography)					
<input type="radio"/> Exercise Stress ECG only (GXT)					
<input type="radio"/> Rest 12-Lead ECG.					
<input type="radio"/> Holter Monitoring: <input type="radio"/> 72 hrs <input type="radio"/> 1 week <input type="radio"/> 2 Weeks <input type="radio"/> Others:					
<input type="radio"/> In-Clinic / Walk-In (9 am – 12 pm and 1 pm to 4 pm)					
<input type="radio"/> By-Mail (by: Xpresspost, prepaid return, all Ontario) - No extra fee					
<input type="radio"/> BP Monitoring (24 Hours) (Not insured and grants are available if requested by patient)					
<input type="radio"/> Cardiology Consultation					
<input type="radio"/> Other:-					
<input type="radio"/> Urgent					
Referring Physician Information (Stamp Label if Available)					
Referring Physician:			Tel:		
Physician's Signature:			Fax:		
			Copy to:		
Billing Provider #:			Note:		
Date: dd/mm/yy:					