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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:					
☐ Chest Pain	☐ SOB	☐ Palpitation	☐ Syncope	☐ Murmur	☐ CVA/TIA
☐ CAD	☐ CHF	☐ Arrhythmias	☐ LL swelling	☐ Others:	
Examination(s) Requested					
☐ Echocardiography (regular comprehensive TTE). Add:- ☐ Bubble Study ☐ Strain Study					
☐ Contrast Echocardiography.					
☐ Pediatric Echocardiography (7 years and older)					
☐ Exercise Stress Echocardiography (SE)					
☐ Ischemic Heart Disease Protocol					
☐ Diastolic Dysfunction Protocol					
☐ Cardiomyopathies Protocol					
☐ Native Valve Disease Protocol					
☐ Exercise Stress ECG only (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 (by: Xpresspost, prepaid return, all Ontario) - No extra fee					
☐ At-Home (by Trained female staff, hook-up, re-hook-up, and pick-up) - No extra fee					
☐ BP Monitoring (24 Hours) (Not insured and grants are available if requested by patient)					
☐ Cardiology Consultation					
☐ Urgent					
Referring Physician Information (Stamp Label if Available)					
Referring Physician:			Tel:		
Physician's Signature:			Fax:		
Billing Provider #:			Copy to:		
Date: dd/mm/yy:			Note:		