1935 Bank Street
1919 Riverside Dr. # 207
Phone: **+1(343) 882-9100**
Fax: **+1(888) 237-9594**
info@ottawacardiology.ca

Ottawa Cardiology Centre

Request For Cardiac Examination

Patient Information (Affix Label if Available)					
Full Name:		E-mail:			
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	◯ Arrythmias	◯ 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 Echo**cardiography **(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:
	Copy to:
Billing Provider #:	Note:
Date: dd/mm/yy:	