ORILLIA CARDIAC CARE

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Website: orilliacardiaccare.ca

Dr. Christopher Nolan *FRCPC, Cardiology, DRCPSC, Advanced Echocardiography*

Consultation Referral Form

Patient Information	
Patient Name:	
Date of Birth (YYYY/MM/DD):	
Address:	
Preferred Phone:	
Health Card #:	

Sex: _____ Pronouns: _____ Height (cm): _____ Weight (kg): _____

Past Medical History: ☐ See Attached CPP

Current Medications: ☐ See Attached CPP

Reason for Referral

☐ Chest Pain ☐ Syncope ☐ Abnormal Testing
☐ Dyspnea ☐ Heart Failure ☐ Other: _____
☐ Palpitations ☐ Cardiac Risk Factors

Reason / Clinical Information:

_____
_____
_____

Consultation Request (select one)

☐ Urgent (<1 week)
☐ Semi-Urgent (1–2 weeks)
☐ Routine (>2 weeks)

Referring Physician Information

Referring Physician: _____ MD's Signature: _____
Billing Number: _____ Fax Number: _____
Copies of reports to: _____ Date of Referral: _____

Please include a patient profile (CPP), relevant labs, prior cardiac investigations, & documentation with this referral.
Fax the completed form and supporting information to: 705-503-6334. Thank-you for your referral.