

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

Diagnostic Imaging Referral Form

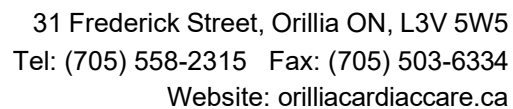
Important Referral Information:

1. Please ***always*** include any/all prior cardiac diagnostic imaging reports along with a current patient profile (CPP) with your referral
2. ***All results will be sent to the referring office for appropriate follow-up by the referring provider***
3. If you would like the Cardiologist to follow-up with your patient, ***if results are abnormal***, please check the box marked ***"Follow-Up with Cardiologist Requested"***
4. ***Fax completed form to: (705) 503-6334***

Patient Information	
Patient Name:	
Date of Birth (YYYY/MM/DD):	
Address:	
Preferred Phone:	
Health Card #:	
Sex: _____ Pronouns: _____ Height (cm): _____ Weight (kg): _____	

Echocardiography	
Transthoracic Echocardiogram	Stress Echocardiogram
☐ LV Function / Suspected CHF ☐ Valvular Disease: Known/ Murmur/ Prosthetic Valve ☐ Arrhythmia ☐ Thoracic Aortic Disease ☐ Pulmonary Hypertension ☐ Other: _____ ☐ Follow-Up with Cardiologist Requested	☐ Chest Pain / Ischemia Evaluation ☐ Hypertrophic Cardiomyopathy ☐ Diastolic Assessment ☐ Valvular Heart Disease ☐ Pulmonary Hypertension ☐ Other: _____ ☐ Follow-Up with Cardiologist Requested

Cardiovascular Diagnostics	
☐ Treadmill Exercise Stress Test ☐ Chest Pain ☐ Palpitations ☐ Cardiovascular Risk Factors ☐ Other: _____ ☐ 12-Lead Resting ECG ☐ Indication: _____ ☐ Follow-Up with Cardiologist Requested	☐ Holter: ☐ 24 hour ☐ 48 hour ☐ 7 days ☐ Palpitations ☐ Syncope ☐ Stroke ☐ Suspected Arrhythmia ☐ Other: _____



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