ORILLIA CARDIAC CARE

31 Frederick Street, Orillia ON, L3V 5W5
Tel: (705) 558-2315 Fax: (705) 503-6334
Website: orilliacardiaccare.ca

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	☐ Chest Pain / Ischemia Evaluation
☐ *Valvular Disease: Known/ Murmur/ Prosthetic Valve*	☐ Hypertrophic Cardiomyopathy
☐ Arrhythmia	☐ Diastolic Assessment
☐ Thoracic Aortic Disease	☐ Valvular Heart Disease
☐ Pulmonary Hypertension	☐ Pulmonary Hypertension
☐ Other: _____	☐ Other: _____
☐ **Follow-Up with Cardiologist Requested**	☐ **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: _____

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Indication / Relevant Medical History
☐ Separate Referral Letter / Supporting Information Attached

Referring Physician Information

Referring Physician: _____ MD's Signature: _____

Billing Number: _____ Fax Number: _____

Copies of reports to: _____ Date of Referral: _____