Orillia Cardiac Care

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

Patient Information

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

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

Past Medical History

_____

_____

_____

_____

Current Medications

_____

_____

_____

_____

Reason for Referral

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

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 all relevant labs, prior cardiac investigations, and documentation with this referral.
Fax completed form to: (705) 503-6334