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Guelph, ON N1E 0L2  
Phone #: 647-255-1615

☐ 512 Coronation Blvd,  
Cambridge, ON N1R 3E5  
Phone #: 647-255-1615

FAX COMPLETED FORM TO  
**647-255-1636**

## Cardiology Requisition

### PATIENT'S INFORMATION

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE #: \_\_\_\_\_  
OHIP #: \_\_\_\_\_  
DOB: \_\_\_\_\_ GENDER: \_\_\_\_\_

### REFERRING PHYSICIAN

REF PHYSICIAN: \_\_\_\_\_  
BILLING #: \_\_\_\_\_  
CLINIC ADD: \_\_\_\_\_  
FAX #: \_\_\_\_\_  
PHONE #: \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_

### CARDIOVASCULAR RISK FACTORS

- |                                    |  |  |   |
|------------------------------------|--|--|---|
| <input type="checkbox"/> SMOKING   | <input type="checkbox"/> DIABETES            | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> FAMILY HISTORY |
| <input type="checkbox"/> STRESS    | <input type="checkbox"/> METABOLIC SYNDROME  | <input type="checkbox"/> DYSLIPIDEMIA SLEEP  | <input type="checkbox"/> OBESITY        |
| <input type="checkbox"/> ETHNICITY | <input type="checkbox"/> SEDENTARY LIFESTYLE | <input type="checkbox"/> APNEA               | <input type="checkbox"/> AGE            |

### CLINICAL INFORMATION

### REFERRAL REASON

- ☐ R/O CAD
- ☐ CHEST PAIN
- ☐ PALPITATION
- ☐ SHORTNESS OF BREATH
- ☐ DIZZINESS
- ☐ HYPERTENSION
- ☐ ABNORMAL ECG
- ☐ MURMUR
- ☐ OTHERS:

### DIAGNOSTIC SERVICES

☐ URGENT

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> CARDIOLOGY CONSULT          | <input type="checkbox"/> ECG/EKG              | <input type="checkbox"/> ECHOCARDIOGRAM | <input type="checkbox"/> STRESS ECHO/ <sup>^^</sup> CONSULT |
| <input type="checkbox"/> HOLTER MONITOR<br>(72 HOUR) | <input type="checkbox"/> 24HR AMBP (NON-OHIP) |   |   |

PLEASE ENSURE THAT THE RELEVANT LAB REPORTS AND MEDICATION LIST  
ARE ATTACHED TO THIS REQUISITION FORM.

<sup>^^</sup> CARDIOLOGY CONSULT MAY BE REQUIRED BEFORE COMPLETING THIS TEST.