REFLEX Cardiology Center

3470 Laird Rd, Unit 1
Mississauga ON L5L 5Y4
Phone #: 289-505-1645

FAX COMPLETED FORM TO
905-822-2665

Cardiology Requisition

PATIENT'S INFORMATION

NAME: _____
ADDRESS: _____
_____
PHONE #: _____
OHIP #: _____

DOB: _____ GENDER: _____

REFERRING PHYSICIAN

REF PHYSICIAN: _____
BILLING #: _____
CLINIC ADD: _____
FAX #: _____
PHONE #: _____
SIGNATURE: _____

CARDIOVASCULAR RISK FACTORS

- ☐ SMOKING
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ FAMILY HISTORY
- ☐ STRESS
- ☐ METABOLIC SYNDROME
- ☐ DYSLIPIDEMIA
- ☐ OBESITY
- ☐ ETHNICITY
- ☐ SEDENTARY LIFESTYLE
- ☐ SLEEP APNEA
- ☐ AGE

CLINICAL INFORMATION

REFERRAL REASON

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

DIAGNOSTIC SERVICES

☐ URGENT

- ☐ CARDIOLOGY CONSULT
- ☐ ECG/EKG
- ☐ ECHOCARDIOGRAM
- ☐ STRESS ECHO/^^ CONSULT
- ☐ HOLTER MONITOR (72 HOUR)
- ☐ 24HR AMBP (NON-OHIP)

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

^^A CARDIOLOGY CONSULT MAY BE REQUIRED BEFORE COMPLETING THIS TEST.