

Mississauga: 102-5602 tenth line W
 Phone: +1(705) 999-3392
 Fax: +1(705) 999-3393
 E-mail: info@diagnosiscentre.ca



☐ **Urgent Request.**

Note: This form can be
 downloaded from:
www.diagnosiscentre.ca

Request For Cardiac Examination

| Patient Information (Affix Label if Available) | | | | | |
|--|--|---|--------------|---------|---------|
| Full Name: | | | | | |
| Address: | Street # & Name: | City: | Postal Code: | | |
| Cell Phone: | | Alt. Phone: | | | |
| Date Of Birth: | dd/mm/yy: | Age: | Gender: | Height: | Weight: |
| Health Card #: | | Family Physician: | | | |
| Clinical Indication | | | | | |
| Clinical Hx: | | | | | |
| <input type="radio"/> Chest Pain | <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Cardiomyopathy: | | | |
| <input type="radio"/> Shortness Of Breath | <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Congenital Heart Disease: | | | |
| <input type="radio"/> Palpitation | <input type="radio"/> Arrhythmias | <input type="radio"/> Valve Replacement: | | | |
| <input type="radio"/> Syncope | <input type="radio"/> CVA/TIA | <input type="radio"/> Pre-Operative: | | | |
| <input type="radio"/> Murmur | <input type="radio"/> Valvular Heart Disease | <input type="radio"/> Chemotherapy: | | | |
| <input type="radio"/> LL swelling | <input type="radio"/> Pulmonary Hypertension | <input type="radio"/> Follow up of: | | | |
| Others: | | | | | |
| Examination(s) Requested | | | | | |
| <input type="radio"/> Echocardiography (regular TTE). Add: <input type="radio"/> Bubble Study <input type="radio"/> Strain Study | | | | | |
| <input type="radio"/> Contrast Echocardiography. | | | | | |
| <input type="radio"/> Exercise Stress Echocardiogram. | | | | | |
| <input type="radio"/> Pediatric Echo (neonate and older) | | | | | |
| <input type="radio"/> Rest 12-Lead ECG. | | | | | |
| <input type="radio"/> Exercise Stress ECG | | | | | |
| <input type="radio"/> Holter Monitoring: <input type="radio"/> 72 hrs <input type="radio"/> 1 week <input type="radio"/> 2 Weeks <input type="radio"/> Others | | | | | |
| <input type="radio"/> In-Clinic <input type="radio"/> By-Mail <input type="radio"/> At-Home | | | | | |
| <input type="radio"/> BP Monitoring (24 Hours) (Not insured by OHIP, free if with Echo or Holter) | | | | | |
| <input type="radio"/> Cardiology Consultation. (in-person/video telecom.) | | | | | |
| <input type="radio"/> Consult on abnormal (if test result is positive/abnormal and clinically indicated for complete evaluation) | | | | | |
| <input type="radio"/> Others:- | | | | | |
| <input type="radio"/> Urgent Request. | | | | | |
| Referring Physician Information (Stamp Label if Available) | | | | | |
| Referring Physician: | | | Tel: | | |
| Physician's Signature: | | | Fax: | | |
| | | | Copy to: | | |
| Billing Provider #: | | | Note: | | |
| Date: dd/mm/yy: | | | | | |