North Bay:304-1950 Algonquin Av
Sudbury: 9-2140 Regent Street
Hearst: 1403 Edward St
Cochrane: 4-233 Eighth St.
Timmins: 214-119 Pine St. S.
Phone: **+1(705) 999-3392**
Fax: +1(705) 999-3393
info@ cardiachealthteams.com

North Bay
Cardiac Health Team

Note: This form can be **Downloaded** from: www.cardiachealthteams.com

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:-

◯ Chest Pain	◯ SOB	◯ Palpitation	◯ Syncope	◯ Murmur	◯ CVA/TIA
◯ CAD	◯ CHF	◯ Arrythmias	◯ LL swelling	◯ Others:	

Examination(s) Requested	**Patient's Cardiologist**
◯ **Echocardiography** (regular comprehensive TTE). **Add:-** ◯ **Bubble** Study ◯ **Strain** Study	◯ **N/A (First Available)**
◯ **Contrast** Echocardiography.	
◯ **Pediatric Echo** (Neonate & older) by dedicated ped Echo Tech, Ped Cardiologist & equipment	◯ **Dr. Anthony Main**
	◯ **Dr. Angelo Dave Javier**
◯ **Rest** 12-Lead **ECG.**	◯ **Dr. Atilio Costa Vitali**
◯ **Holter** Monitoring: ◯ 72 hrs ◯ 1 week ◯ 2 Weeks ◯ Others:	◯ **Dr. Brian Wong**
◯ **In-Clinic** / Walk-In (9 am – 12 pm and 1 pm to 4 pm)	◯ **Dr. Djilali Hanzal**
◯ **By-Mail (by: Xpresspost,** prepaid return, all Ontario) - No extra fee	◯ **Dr. Grama Ravi**
◯ **At-Home** (by Trained **female** staff, hook-up, re-hook-up, and pick-up) - No extra fee	◯ **Dr. Raed Abu Shama**
	◯ **Dr. Roger Labonte**
◯ **BP Monitoring** (24 Hours) (Not insured and **grants are available** if requested by patient)	◯ **Dr. Samantha Liauw**
	Pediatric Cardiology Team
◯ **Cardiology Consultation** ◯ **Virtual** (**only** first available)	◯ **Dr. Angelo Dave Javier**
◯ **In-Person**	◯ **Dr. Yousef Etoom**
◯ **Consult on Abnormal**	
◯ Other:-	**Locations: -**
	◯ **North Bay**
	◯ **Sudbury**
	◯ **Timmins**
◯ **Urgent**	◯ **Cochrane**
◯ **STAT Report** (technologist impression before read by cardiologists)	◯ **Hearst**

Referring Physician Information (Stamp Label if Available)	
Referring Physician:	Tel:
Physician's Signature:	Fax:
	Copy to:
Billing Provider #:	Note:
Date: dd/mm/yy:	