

Iroquois Falls: 58A Anson Drive
Timmins: 133-38 Pine St. N.
Cochrane: 4-233 Eighth St.
Sudbury: 9-2140 Regent St.
North Bay: 304-1950 Algonquin Av
Temiskaming Shore: 2-240 Shepherdson
Hearst: 1403 Edward St



Iroquois Falls Cardiac Health Teams

Download this form from:
<https://cardiachealthteams.com>

Phone: +1(705) 999-3392
 Fax: +1(705) 999-3393
 info@cardiachealthteams.com

Test For Cardiac Examination

Patient Information (Affix Label if Available)					
Full Name:		Gender:	Height:	Weight:	
Address:	Street # & Name:	City:	Postal Code:		
Health Card #:		Cell Phone			
Date Of Birth:	dd/mm/yy:	Age:	Family Physician:		
Clinical Indication					
Clinical Hx:-					
☐ Chest Pain	☐ SOB	☐ Palpitation	☐ Syncope	☐ Murmur	☐ CVA/TIA
☐ CAD	☐ CHF	☐ Arrhythmias	☐ LL swelling	☐ Others:	
Examination(s) Requested				Patient's Cardiologist	
☐ Echocardiography (regular comprehensive TTE). Add:- ☐ Bubble Study ☐ Strain Study ☐ Bubble Study ☐ Strain Segmental Analysis				☐ N/A (First Available)	
				☐ Dr. Anthony Main	
				☐ Dr. Atilio Costa Vitali	
☐ Contrast Echocardiography.				☐ Dr. Brian Wong	
☐ Pediatric Echocardiography.				☐ Dr. Djilali Hanzal	
☐ Rest 12-Lead ECG.				☐ Dr. Grama Ravi	
☐ Holter Monitoring: ☐ 72 hrs ☐ 1 week ☐ 2 Weeks ☐ Others:				☐ Dr. Mohamed Ibrahim	
☐ In-Clinic / Walk-In (9 am – 12 pm and 1 pm to 4 pm)				☐ Dr. Mohamed Shurrab	
☐ By-Mail (by: Xpress post, prepaid return, all Ontario) - No extra fee				☐ Dr. Raed Abu Shama	
☐ At-Home (by Trained female staff, hook-up, re-hook-up, and pick-up) - No extra fee				☐ Dr. Roger Labonte	
☐ BP Monitoring (24 Hours) (Not insured and grants are available if requested by patient)				☐ Pediatric Cardiology Team	
☐ Simple Spirometry.				☐ Dr. Yousef Etoom	
☐ Cardiology Consultation ☐ Virtual ☐ In-Person (In Sudbury)				☐ Level III Echo Cardiologists	
				☐ Dr. Mohamed Ibrahim	
				☐ Dr. Djilali Hanzal	
				☐ Electrophysiology Team	
☐ Urgent				☐ Dr. Raed Abu Shama	
				☐ Dr. Atilio Costa Vitali	
				☐ Dr. Mohamed Shurrab	
Referring Physician Information (Stamp Label if Available)					
Referring Physician:			Tel:		
Physician's Signature:			Fax:		
			Copy to:		
Billing Provider #:			Note:		
Date: dd/mm/yy:					