Temiskaming Shores: 2-240 Shepherdson
Iroquois Falls: 58A Anson Drive
Timmins: 117-38 Pine St. N.
Cochrane: 4-233 Eighth St.
North Bay: 304-1950 Algonquin Av
Hearst: 1403 Edward St
Sudbury: 9-2140 Regent St.

Temiskaming Shores Cardiac Health Teams

Download this form: https://cardiachealthteams.com

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

Request 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	◯ Arrythmias	◯ LL swelling	◯ Others:	

Examination(s) Requested	Patient's Cardiologist
◯ **Echocardiography** (regular comprehensive TTE). **Add:-** ◯ **Bubble** Study ◯ **Strain** Study	◯ **N/A (First Available)**
◯ **Bubble** Study	
◯ **Strain** Segmental Analysis	◯ **Dr. Anthony Main**
	◯ **Dr. Atilio Costa Vitali**
◯ **Contrast** Echocardiography.	◯ **Dr. Brian Wong**
	◯ **Dr. Djilali Hanzal**
◯ **Pediatric Echocardiography.**	◯ **Dr. Grama Ravi**
	◯ **Dr. Mohamed Ibrahim**
◯ **Rest** 12-Lead **ECG.**	◯ **Dr. Mohamed Shurrab**
	◯ **Dr. Raed Abu Shama**
◯ **Holter** Monitoring: ◯ 72 hrs ◯ 1 week ◯ 2 Weeks ◯ Others:	◯ **Dr. Roger Labonte**
◯ **In-Clinic** / Walk-In (9 am – 12 pm and 1 pm to 4 pm)	
◯ **By-Mail (by: Xpress post,** prepaid return, all Ontario) - No extra fee	**Pediatric Cardiology Team**
◯ **At-Home** (by Trained **female** staff, hook-up, re-hook-up, and pick-up) - No extra fee	◯ **Dr. Yousef Etoom**
	◯ **Dr. Wald Rachel**
◯ **BP Monitoring** (24 Hours) (Not insured and **grants are available** if requested by patient)	**Level III Echo Cardiologists**
	◯ **Dr. Mohamed Ibrahim**
	◯ **Dr. Djilali Hanzal**
◯ **Cardiology Consultation** ◯ **Virtual** ◯ **In-Person (In Sudbury)**	
	Electrophysiology Team
	◯ **Dr. Raed Abu Shama**
◯ **Urgent**	◯ **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:	