

Cardiology Team
Dr. Indra Warren <i>MD, FRCPC</i>
Dr. Paul Hong <i>MBChB, FRCPC, MRCP(UK), CCDS</i>
Dr. Waseem Hindieh <i>MD, FRCPC</i>
Dr. Philippe R. Beaudry <i>MD, FRCPC, FACC, FASE</i>
Dr. Mina Girgis <i>MD, FRCPC</i>
Dr. Deejo Mohamud <i>MD, FRCPC</i>
Dr. Brett J. Stevens <i>MD, FRCPC</i>

Patient Information
Name: _____
Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address: _____ _____
City: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____
OHIP Number: _____ Version code: _____

Requested Cardiologist
<input type="checkbox"/> Dr. _____ <input type="checkbox"/> First Available

Consult Urgency
<input type="checkbox"/> URGENT <input type="checkbox"/> Routine

Reason for Referral

Past Medical History / Current Medications

Diagnostic Testing
<input type="checkbox"/> 12-Lead Electrocardiogram
<input type="checkbox"/> Exercise Stress Test
<input type="checkbox"/> Echocardiogram <input type="checkbox"/> with Contrast
<input type="checkbox"/> Stress Echocardiogram <input type="checkbox"/> with Contrast
Patch Holter Monitor:
<input type="checkbox"/> 48-hr <input type="checkbox"/> 7-day
<input type="checkbox"/> 72-hr <input type="checkbox"/> 14-day
<input type="checkbox"/> 24-hr Ambulatory BP Monitor
<i>**not covered by OHIP - \$60.00 fee</i>

Referring Physician
Name: _____
Address: _____
Phone #: _____ Fax #: _____
Signature: _____ Billing #: _____
CC: _____ Date of Referral: _____

Please attach previous ECGs, imaging reports, and most recent bloodwork with referral