CARDIO-CARE HEART INSTITUTE

REFERRAL FORM

Dr. George Farag, M.B.B.Ch, FRCPC, FACC | *Cardiologist*

TEL (519) 541-0030 | FAX (519) 339-0993 | 333 George Street, Sarnia N7T 4P5 | www.sarniacardiocare.com

Date of referral:(yyyy/mm/dd)_____

Patient Name: _____ (LAST) _____ (FIRST) ☐ In Patient ☐ Out Patient

Address: _____ City: _____ Postal Code: _____

Home Phone Number: _____ Work Phone Number: _____ Cell Phone Number: _____

DOB (yyyy/mm/dd): _____ / _____ / _____ Health Card Number/Version Code: _____

Referring Physician Name: _____ (Please Print) Physician Provider Number: _____

Address: _____ Phone: _____ Fax: _____

DIAGNOSIS / REASON FOR REFERRAL :

CARDIO-CARE CARDIAC MANAGEMENT

CARDIAC TESTING

CHEST PAIN / CAD
- ☐ ECG
- ☐ Echo Doppler
- ☐ Stress EKG
- ☐ Stress Echo
  - ☐ Dobutamine
  - ☐ Excercise
- ☐ Nuclear Perfusion Imaging
  - ☐ Rest/Exercise
  - ☐ Persantine
  - ☐ Dobutamine
  - ☐ Viability Study (Thallium)

LV / CHF / HTN
- ☐ ECG
- ☐ Echo Doppler
- ☐ 24 Hour Ambulatory BP
- ☐ MUGA

INHERITED/CONGENITAL HEART DISEASE
(HCM, ARVC, etc.)

AORTIC DISEASE
(Aortic Root/Ascending Aorta Dialation, Aneurysm, etc.)

ARRHYTHMIA
- ☐ ECG
- ☐ Echo Doppler
- ☐ 24 Hour Holter
- ☐ 48 Hour Holter
- ☐ 72 Hour Holter
- ☐ 5 Day Holter
- ☐ 7 Day Holter

Cardiac Consultation

URGENCY
- ☐ Urgent
- ☐ Semi-Urgent
- ☐ Elective
- ☐ Follow Up

Cardiologist Consultation if test abnormal (Same day if high risk results)

REQUESTED SERVICES :

- ☐ Consultation - General Cardiology
- ☐ Consultation - Heart Failure
- ☐ Echocardiogram Only (Bubble Study/Contrast would be added of technically required)
- ☐ Stress Test (Consult Included)
- ☐ Stress Echo
- ☐ Transesophageal Echo (TEE)
- ☐ Holter Monitor
  - ☐ 24 Hour ☐ 48 Hour ☐ 72 Hour
  - ☐ 7 Days ☐ 14 Days
- ☐ MIBI
- ☐ Exercise
- ☐ Persantine
- ☐ Dobutamine
- ☐ Other: _____

Referring Physician Signature: _____ Date: _____

PLEASE FAX referral form to 519-339-0993