

Cardiology Team
<b>Dr. Indra Warren</b> <i>MD, FRCPC</i>
<b>Dr. Paul Hong</b> <i>MBChB, FRCPC, MRCP(UK), CCDS</i>
<b>Dr. Waseem Hindieh</b> <i>MD, FRCPC</i>
<b>Dr. Philippe R. Beaudry</b> <i>MD, FRCPC, FACC, FASE</i>
<b>Dr. Mina Girgis</b> <i>MD, FRCPC</i>
<b>Dr. Deejo Mohamud</b> <i>MD, FRCPC</i>
<b>Dr. Brett J. Stevens</b> <i>MD, FRCPC</i>
<b>Dr. Kimesh Chetty</b> <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 <input type="checkbox"/> Consult if abnormal test results

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

Reason for Referral

Past Medical History / Current Medications
Please attach previous ECGs, imaging reports, and most recent bloodwork

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 **not covered by OHIP - \$60.00 fee

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