PRIME MEDICAL CENTRE

REFERRAL FORM

TORONTO	MISSISSAUGA
1-68 Abell St	3-755 Queensway East
Phone: 416-532-8181	Phone: 905-897-5454
Fax: 416-532-0268	**Fax: 905-897-7494**

Referral Date (DD/MM/YY): Urgency: ○ Routine ○ Semi-urgent ○ Urgent

PATIENT INFO

Patient Name:

Complete Address: (including postal code)

Date of Birth: Gender: M ○ F ○

Phone:

PHN:

PHYSICIAN INFO

Referring Physician:

Billing #:

Phone: Fax:

Family MD:

CC Dr.:

MD Signature:

CARDIOLOGY SERVICES: ☐ With Consult

- ☐ **Echocardiogram**
- ☐ **Exercise Stress Test**
- ☐ **ECG**
- ☐ **Ambulatory BP Monitor** (Not Covered by OHIP)
- ☐ **Holter Monitor**
  - ☐ **48 Hour**
  - ☐ **72 Hour**
  - ☐ **2 weeks**

INDICATION:

☐ Chest pain	☐ CHF	☐ Murmur
☐ Dyspnea	☐ CAD	☐ Arrhythmia
☐ Palpitations	☐ HTN	☐ Valvular Disease
☐ Syncope	☐ Dizziness	☐ Abnormal ECG
☐ Edema	☐ Other: _____	

☐ **INTERNAL MEDICINE**

- ☐ Comprehensive Medical Review
- ☐ Cardiac Review (CP, SOB, palpitations)
- ☐ Vascular health (Obesity, DM, HTN, DLP)
- ☐ Fatigue
- ☐ Other: _____

☐ **IRON INFUSION ASSESSMENT**

☐ **ORTHOPEDIC SURGERY**

- ☐ With Physiotherapy
  - ☐ Back or Joint Pain
  - ☐ Osteoarthritis
  - ☐ Common Pediatric Conditions
  - ☐ Other: _____

ADDITIONAL HISTORY: (Please attach medical profile and recent investigations with referral)