



REFERRAL FORM

2-1120 Kingston Rd, Scarborough, ON
Phone: 416-690-7111

Fax: 416-690-4111

Referral Date (DD/MM/YY):

Urgency: ☐ Routine ☐ Semi-urgent ☐ Urgent

PATIENT INFORMATION

Full Name: _____

HIN/UCI: _____

Address: _____

D.O.B: _____

Gender: _____

Tel No.: _____

Cell No.: _____

E-mail: _____

REFERRING PHYSICIAN

Name: _____

Billing No.: _____

Address: _____

Tel No.: _____

Fax No.: _____

MD Signature: _____

CARDIOLOGY SERVICES: ☐ With Consult

☐ ECG

☐ Echocardiogram

☐ 48hr Holter

☐ 72hr Holter

☐ 2 week Holter

INDICATION:

☐ Chest pain

☐ Edema

☐ HTN

☐ Arrhythmia

☐ Dyspnea

☐ CHF

☐ Dizziness

☐ Valve Disease

☐ Palpitations

☐ CAD

☐ Murmur

☐ Abnormal ECG

☐ Syncope

☐ Other: _____

OTHER SERVICES:

☐ Iron Infusion Assessment

☐ Internal Medicine Consultation

Reason for Referral: _____

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