CARDIOCARE HEART INSTITUTE

REFERRAL FORM

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

FAX 519-339-0993 | TEL 519-541-0030 | 714 London Road, Sarnia, ON N7T 4X6 | www.sarniacardiocare.com

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

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

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: _____ Physician Provider Number: _____
(Please Print)

Address: _____ Phone: _____ Fax: _____

DIAGNOSIS / REASON FOR REFERRAL:

CARDIO-COR CARDIAC MANAGEMENT

Cardiac Testing*

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

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

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

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

ARRHYTHMIA
- ☐ EKG
- ☐ Echo Dopplar
- ☐ 24 Hour Holter
- ☐ 48 Hour Holter
- ☐ 72 Hour Holter
- ☐ 5 Day Holter
- ☐ 7 Day Holter

Cardiac Consultation

URGENCY
- ☐ Urgent

REASON

- ☐ 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 if 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 or EMAIL from our website www.sarniacardiocare.com