Cardiology One

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GENERAL REFERRAL FORM

PATIENT INFORMATION/LABEL:

NAME:

PHN:

PHONE:

GENDER:

DOB:

REFERRING PHYSICIAN:

NAME:

PRACID:

PHONE:

FAX:

REQUEST DATE:

CARDIODIAGNOSTIC TESTS

- ☐ TRANSTHORACIC ECHOCARDIOGRAM & CAROTID DOPPLER
- ☐ TRANSTHORACIC ECHOCARDIOGRAM & ECG
- ☐ TRANSTHORACIC ECHOCARDIOGRAM
- ☐ CAROTID DOPPLER
- ☐ HOLTER MONITOR & ECG
- ☐ ECG

INDICATION:

CLINICAL CONSULTATION (PLEASE PROVIDE RELEVANT REPORTS/DOCUMENTS)

URGENT (2 wk):

- ☐ High risk cardiac tests
- ☐ Typical chest pain/anginal equivalent
- ☐ New symptomatic heart failure (+ BNP and or significant LV dysfunction)
- ☐ New severe aortic stenosis

SEMI URGENT (2 wk):

- ☐ Untreated atrial fibrillation/flutter
- ☐ Stable chest pain
- ☐ CV risk stratification (preoperative/oncology)
- ☐ Documented arrhythmia
- ☐ New at least moderate valvular heart disease
- ☐ High risk syncope*

ROUTINE (4-16 wk):

- ☐ Atypical chest pain/dyspnea
- ☐ Known asymptomatic LV dysfunction
- ☐ Treated atrial fibrillation
- ☐ CV risk stratification
- ☐ Abnormal ECG
- ☐ Palpitations
- ☐ Low risk syncope**
- ☐ **PREGNANCY/PERIPARTUM CARDIOLOGY (1-2 wk)**
- ☐ **PHYSICIAN PHONE ADVICE (1-2 wk)**

*Known coronary artery or structural heart disease, heart failure, arrhythmia, family history of sudden cardiac death etc.

**Prodrome, situational triggers, postural, no cardiac history or young, healthy with no significant medical history.

CONTACT INFORMATION

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