Chahal Cardiovascular Centre

REFERRAL FORM

3495 Rebecca Street, Suite 106-107
Oakville, Ontario L6L 0H5, Canada
O 905 337 7773 F 905 337 1198

PATIENT INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____

Health Card Number: _____

REASON FOR REFERRAL

General Cardiology:

- ▫ Preventative Health Clinic
- ▫ Women's Cardiovascular Health Clinic
- ▫ Coronary Artery Disease & Lipid Clinic
- ▫ Arrhythmia Clinic
- ▫ Peripheral Vascular Clinic

Advanced Heart Failure:

- ▫ Advanced HF Assessment
- ▫ Cardio-Oncology Clinic
- ▫ Cardio-Obstetrics Clinic
- ▫ Pre-VAD or Pre-Transplant Assessment

Pulmonary Hypertension:

- ▫ Pulmonary Hypertension Clinic

Cardiovascular Surgery:

- ▫ Cardiovascular Surgery Clinic
- ▫ Post-VAD or Post-Transplantation Clinic

Additional Info:

_____

_____

_____

_____

Diagnostic Testing:

- ▫ Electrocardiogram (ECG)
- ▫ Holter Monitor
  - ▫24h ▫48h
  - ▫72 hr ▫7d
- ▫ Exercise Treadmill Test
- ▫ Exercise Echocardiogram
- ▫ Echocardiography & Doppler Ultrasound
- ▫ Cardiopulmonary Stress Test
- ▫ Ambulatory Blood Pressure Monitor

- ▫ Diagnostic testing with consultation
- ▫ Diagnostic testing without consultation

LEVEL OF URGENCY

- ▫ Routine
- ▫ Semi Urgent (2 wks)
- ▫ Urgent (48 h)

PLEASE SEND WITH REFERRAL

- ▫ Medication List
- ▫ Recent Bloodwork
- ▫ Previous Cardiac Imaging Studies
- ▫ Previous Cardiac Procedures/Surgery Reports

REFERRING DOCTOR

Name: _____ Address: _____

Billing Number: _____ CPSO Number: _____

Signature: _____ Date: _____

Please fill out and fax to (905) 337-1198. If you have any questions, please contact our clinic at (905) 337-7773 or info@chahalcardiovascularcentre.com. If you require additional information, please visit our website at www.chahalcardiovascularcentre.com.