Sudbury: 9-2140 Regent St.
Phone: +1(705) 885-1750
Fax: +1(705) 419-2939
info@sudburycardiology.ca

Sudbury Cardiology Centre

◯ **Urgent Request.**

Note: This form can be **Downloaded** from: **www.sudburycardiology.ca**

Request For Cardiac Examination

Patient Information (Affix Label if Available)					
Full Name:					
Address:	Street # & Name:		City:		Postal Code:
Cell Phone:		Alt. Phone:			
Date Of Birth:	dd/mm/yy: Age:	Gender:	Height:	Weight:	
Health Card #:		Family Physician:			

Clinical Indication		
Clinical Hx:-		
◯ Chest Pain	◯ Coronary Artery Disease	◯ Cardiomyopathy:
◯ Shortness Of Breath	◯ Congestive Heart Failure	◯ Congenital Heart Disease:
◯ Palpitation	◯ Arrythmias	◯ Valve Replacement:
◯ Syncope	◯ CVA/TIA	◯ Pre-Operative:
◯ Murmur	◯ Valvular Heart Disease	◯ Chemotherapy:
◯ LL swelling	◯ Pulmonary Hypertension	◯ Follow up of:

Examination(s) Requested	**Cardiologists**
◯ **Echocardiography** (regular **comprehensive** TTE). **Add:**-	◯ Dr. Grama **Ravi**
◯ **Bubble** Study.	
◯ **Strain** Analysis.	
◯ **Contrast** Echocardiography.	
◯ **Exercise Sress Echocardiography**.	
◯ **Pediatric Echocardiography.**	
◯ **Rest** 12-Lead **ECG.**	
◯ **Exercise Stress ECG.**	
◯ **Holter** Monitoring: ◯ 72 hrs ◯ 1 week ◯ 2 Weeks	
◯ **By-Mail** (Xpresspost)	
◯ **Walk-In In-Clinic**	
◯ **At-Home**	
◯ **BP Monitoring** (24 Hours ABPM) (Not insured by OHIP)	
◯ **Cardiology Consultation (Adult)**	
◯ **Action on significantly abnormal.**	
◯ **Urgent**	
◯ Other:-	

Referring Physician Information (Stamp Label if Available)	
Referring Physician:	Tel:
Physician's Signature:	Fax:
	Copy to:
Billing Provider #:	Note:
Date: dd/mm/yy:	