



Heart & Vascular

CENTRE FOR CARDIOLOGY

www.heartandvascularcardiology.com

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STONEY CREEK 35 Upper Centennial Pkwy, 2nd flr L8J 3W2

HAMILTON 414 Victoria Ave N. Suite M7 L8L 5G8 - **NEW**

BURLINGTON 2079 Lakeshore Road L7R 1E2

CARDIAC DIAGNOSTICS TESTING

- ☐ Treadmill Exercise Stress Test (GXT)
- ☐ Recumbent Bike Exercise Stress Test
** Suitable for patients who are unable to walk on a treadmill*
- ☐ Cardiac LOOP Event Monitor
14 Days of Continuously Monitoring Cardiac Events
- ☐ ABPM (Ambulatory Blood Pressure Monitor)
** \$60 charge to patient*
- ☐ HOLTER Monitor ☐ 48 HR ☐ 24 HR
- ☐ 2D Echocardiogram
- ☐ ECG

PULMONARY FUNCTION STUDIES

- ☐ Spirometry with Flow Volume Loop
- ☐ Pre /Post Bronchodilator

REFERRING PHYSICIAN - PLEASE COMPLETE

Referring Physician:

Signature Required:

Address:

Billing Number:

Phone Number:

Fax Number:

Date:

CARDIOLOGY

- ☐ 1st Available Cardiologist
- ☐ Dr.

CHOOSE PREFERRED LOCATION

- ☐ Stoney Creek
- ☐ Hamilton
- ☐ Burlington

REASON FOR CONSULT - PLEASE COMPLETE

- PLEASE INDICATE ONE:**
- ☐ Consultation & Diagnostic Testing (Choose below OR leave for Cardiologist to determine).
 - ☐ Consultation if abnormal test results
 - ☐ No Consultation Required. Diagnostic Testing Only.

- ☐ Abnormal ECG
- ☐ Arrhythmia/Palpitations
- ☐ CHF
- ☐ Chest Pain
- ☐ Dyspnea
- ☐ Dizziness/Syncope
- ☐ HTN

Clinical Information (or attach) :

PATIENT INFORMATION - PLEASE COMPLETE OR ATTACH LABEL

Last Name: <input type="text" value="patSurname"/>		First: <input type="text" value="patName"/>		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Street Address: <input type="text" value="patStreetAddress"/>		City: <input type="text" value="patCityAddress"/>		Province: <input type="text" value="patProvince"/>
Home Phone: <input type="text" value="patHomePhone.default"/>	Mobile: <input type="text" value="patMobilePhone.default"/>		Postal Code: <input type="text" value="patPostalCode"/>	
Email: <input type="text" value="patEmail"/>			Date of Birth: <input type="text" value="patBirthdate.default"/>	
Appointment Date:		Appointment Time: <input type="checkbox"/> AM <input type="checkbox"/> PM		
OHIP Number: <input type="text" value="patHN"/> ...ersionCode				

PLEASE FAX ALL REFERRALS TO THE CENTRAL BOOKING LINE 1-855-210-0758

*** For URGENT referrals please call our CENTRAL BACK LINE at 1-855-210-0707 or indicate on referral ***