ONTARIO CARDIOVASCULAR ASSOCIATES

CARDIAC EXAMINATION REQUISITION

Niagara Falls: 6387 Morrison St
Phone: +1 (289) 271-2100
Fax: +1 (855) 913-2516
office@ocaheart.ca

PATIENT INFORMATION | Affix label if available

Full name: _____

Address: _____ City: _____ Postal: _____

Cell: _____ Alt. phone: _____ DOB: _____

Health card #: _____ Family physician: _____

CLINICAL INDICATION

Clinical history / relevant details:

_____

_____

_____

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Syncope
- ☐ Murmur
- ☐ Leg swelling
- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ Arrhythmias
- ☐ CVA / TIA
- ☐ Valvular heart disease
- ☐ Pulmonary hypertension
- ☐ Cardiomyopathy
- ☐ Congenital heart disease
- ☐ Valve replacement
- ☐ Pre-operative evaluation
- ☐ Chemotherapy
- ☐ Follow-up

EXAMINATION(S) REQUESTED

- ☐ Echocardiography - comprehensive TTE
- ☐ Bubble study
- ☐ Strain analysis
- ☐ Contrast echocardiography
- ☐ Exercise stress echocardiography
- ☐ Pediatric echocardiography
- ☐ Resting 12-lead ECG
- ☐ Exercise stress ECG
- ☐ Holter monitoring ☐ 72 hr ☐ 1 week ☐ 2 weeks

ADDITIONAL REQUESTS / NOTES

- ☐ 24-hour BP monitoring (ABPM)
  (not insured by OHIP)
- ☐ Adult cardiology consultation
- ☐ Urgent ☐ Other
- ☐ Action on significant abnormality

Comments:

_____

_____

_____

REFERRING PHYSICIAN INFORMATION | Stamp if available

Referring physician: _____ Phone: _____

Physician signature: _____ Fax: _____

Billing provider #: _____ Date: _____ Copy to: _____