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MyHealth | CENTRE

BRANT CARDIOLOGY ASSOCIATES
BRANTFORD HEALTH CLINIC
40 Shellington Place
Brantford, ON N3S 0C5
Tel: 519-753-9581 ext. 3029 | Fax: 519-753-9547
www.myhealthcentre.ca

Dr. A. Akram Dr. A. Mundi Dr. R.M. Iwanochko Dr. E. Downar Dr. H. Amad Dr. C. Labos Dr. P. Kannampuzha

PATIENT INFORMATION:

PATIENT'S NAME: _____ D.O.B: _____ ☐ F ☐ M

ADDRESS: _____

TELEPHONE #: _____ HEALTH CARD #: _____

Check if applicable ☐ **STAT**

CARDIOLOGY TESTING

☐ 12-LEAD ELECTROCARDIOGRAM (ECG)

☐ HOLTER MONITORING

☐ 24 hrs ☐ 48 hrs ☐ 72 hrs ☐ ____ hrs/wks/mths

Appointment: _____

☐ ECHOCARDIOGRAM (COLOUR DOPPLER)

Please select one of the following indications:

☐ Chest pain suspicious of CAD
☐ Congestive heart failure
☐ Palpitations / arrhythmias
☐ Other: _____
☐ Murmur
☐ Hypertension
☐ Syncope

Appointment: _____

Weight: _____ **Height:** _____

CARDIOLOGY CONSULTATION

☐ CONSULTATION REQUESTED

Indication(s) for consultation:

☐ Abnormal Exercise / Rest ECG
☐ Atypical (variant) Angina
☐ Typical Angina
☐ Rule out CAD (CRF with symptoms)
☐ Post M.I.
☐ Other: _____

Appointment: _____

Clinical Information: _____

_____

Referring Physician: _____ _____
Print Name Signature

Phone #: _____ Fax #: _____

Copy To: _____ Fax #: _____
Print Name

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF program. Website: http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx