C·health is now WELL Health | DIAGNOSTIC CENTRES

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DIAGNOSTIC SERVICE & CARDIOMETABOLIC ASSESSMENT REQUISITION

PATIENT INFORMATION (attach patient label)

Patient Name: ☐M ☐F
ULI: DOB:
Address: Postal Code:
City, Province: Home phone:
Email:

Referral Date: _____

☐ URGENT TESTING REQUESTED

PULMONARY DIAGNOSTIC SERVICES

- ☐ Pulmonary Function Test (PFT)
  - ☐ Include Smoking Cessation
  - ☐ Include Medication/Inhaler Education & Review
- ☐ Spirometry Only

CLINICAL SERVICES

- ☐ Cardiovascular Assessment & Consultation
  Provided by Internist and/or Cardiologist based on patient complexity

CARDIOMETABOLIC ASSESSMENT

- ☐ Risk Assessment
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Other: _____
- ☐ Syncope
- ☐ Abnormal ECG
- ☐ Atrial Fibrillation

CARDIAC DIAGNOSTIC SERVICES

- ☐ Nuclear Cardiology Studies
  MUST include recent ECG
- ☐ Exercise Stress Test
  MUST include recent ECG
- ☐ ECG
- ☐ Holter Monitor
  - ☐ 48 hour
  - ☐ Other: _____
- ☐ ABPM (24 hour)
- ☐ Echocardiogram (including GLS)

Medical History & Notes: *For cardiac stress testing, please note any patient respiratory or mobility concerns below.*

Pre-test Probability of CAD: ☐ Low ☐ Intermediate ☐ High

Is your patient currently taking any: ☐ Beta Blockers ☐ Calcium Channel Blockers ☐ N/A

REFERRING PHYSICIAN INFORMATION

Referring Clinic: _____
Phone: _____ Fax: _____
Physician Name: _____
PRAC ID#: _____

Referring Physician Signature: