

Our Vision is to provide the highest quality cardiac care services by ensuring rapid access to advanced diagnostic testing and consultation

Patient Information

Name: _____ DOB: _____
Address: _____ City: _____ Postal Code: _____
Health Card / Version Code: _____ Phone: _____ Cell: _____ Email: _____
Reason for Referral: _____
Medication: _____ Height: _____ in. Weight _____ lbs. Smoker ☐

Referring Healthcare Provider

Referring Provider Name: _____ Billing #: _____
E-Mail: _____ Fax: _____ Preferred Report Delivery: ☐ E-Mail ☐ Fax
Copies of reports to: _____
Referring Provider Signature: _____

Specialist Services

- | | |
|--|---|
| ☐ Cardiology Consult
☐ First available
☐ Within one week
☐ Saturday
☐ Dr. _____ | ☐ Neurology Consult
☐ Neurology Follow-up
☐ Nerve Conduction Study
☐ Dr. Chern Lim |
| ☐ Cardiology Follow-up | |
| ☐ Consult if Test Result is Positive/Abnormal | |

Cardiac Testing

- | | | |
|---|---|---|
| ☐ Electrocardiogram (ECG)
☐ Echocardiogram ☐ Strain ☐ +Contrast
☐ Holter ☐ 24h ☐ 48h ☐ 72h
☐ Other: _____ | ☐ Exercise Stress Test
☐ Stress Echocardiogram
☐ Exercise
☐ Dobutamine
☐ 24-hour Ambulatory BP | ☐ Myocardial Perfusion Imaging (MPI)
☐ Exercise
☐ Persantine
☐ MUGA (RNA)
☐ Cardiac Amyloid Scan |
|---|---|---|

General Nuclear Medicine

- | | | |
|---------------------------------------|---|--|
| ☐ Bone Scan | ☐ Parathyroid Scan | ☐ Gastric Emptying Scan (Solid) |
| ☐ Thyroid Scan | ☐ Renal Scan | |

Locations

