Acute Cardiac Evaluation Services

Referral Form

Name _____ Address _____

DOB _____ _____

Telephone _____ _____

OHIP_____ Family MD _____

Reason for referral:

- o Chest pain / Coronary Artery Disease
- o Syncope / Arrhythmia
- o CHF
- o Atrial Fibrillation
- o Other _____

Requested Investigations:

- o Cardiac Stress Test
- o **Known previous CAD (patient to continue current meds)**
- o **No previous CAD (patient to hold rate reducing meds prior to test)**
- o ECG
- o Holter Monitor __ 24hr __ 48hr __ 72hr __ 7 day __ 14 day
- o Loop Monitor (14 days)
- o ECHO (please fill out and attach appropriate requisition)

Please fax referral to **705 325 3985**

Attach patient profile, if available

For **ER referrals** please forward **ER profile sheet** with this referral to the ward clerk

Referring MD:_____

Signature:_____ Date:_____