Soldiers' MEMORIAL HOSPITAL Orillia

Apply Patient Label Here with min. of Name, DOB, Health Card #

Acute Cardiac Evaluation Services Form

**Note: Incomplete or illegible forms will be sent back requesting amendment*

Referral Information:

Date Sent	
Referring Physician	Physician Name (print): _____ Physician Signature: _____ Physician CPSO #: _____
Office Telephone #	
Office Fax #	

Patient Information:

Patient Name	
Patient DOB	
Primary Phone #	
Alternate Phone #	
Health Card # & Version Code	
OSMH MRN (if applicable)	
Reason for Referral:	☐ Chest Pain / Coronary Artery Disease ☐ Syncope / Arrhythmia ☐ CHF ☐ Atrial Fibrillation ☐ Other: _____
Requested Investigations:	☐ Cardiac Stress Test ☐ Known previous CAD (pt to continue current meds) ☐ No previous CAD (patient to hold rate reducing meds prior to test) ☐ ECG ☐ Holter Monitor: ☐ 24hr ☐ 48hr ☐ 72hr ☐ 7 day ☐ 14 day ☐ Loop Monitor – 14 days ☐ ECHO (please fill out and attach appropriate requisition)

Important Note Regarding Supporting Documentation:

Please note: Documentation is required to support this referral, e.g. Emergency report, prior diagnostics etc. Referrals without supporting documentation will be sent back to the requesting provider.