

Cardiac Stress Test Referral Form

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

Patient Information:

Patient Name		
Patient DOB		
Primary Phone #		Alt Phone #:
Health Card # & Version Code		
OSMH MRN (if applicable)		

Required Tests:

- Cardiolute (1-3 hours) Stress cardiolute (including immediate post stress and rest wall motion/ejection fraction assessment) (Patient must come back the next day)
- Persantine (1-3 hours) Persantine Cardiolute (including immediate post stress and rest wall motion/ejection fraction assessment) (Patient must come back the next day)

Diagnosis: _____

Cardiac History:

- Prior MI – Date _____ Location: Anterior Inferior Posterior
- CHF Hypertension Dysrhythmias _____
- Previous cardiac testing or procedures: _____

Other History: Asthma COPD Diabetes Other: _____

Medications: Nitrates Beta-Blocker Calcium Channel-Blocker ASA Digoxin Anti-Arrhythmic
 ACE-Inhibitor Diuretic Other: _____

Known Allergies: _____

BMI: _____

Referral Information:

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

Cardiac Stress Test Preparation Instructions:

The tests are intended to assist the physician in determining and/or treating persons with heart disease.

How do I prepare for my testing:

- Please wear loose fitting clothing, two-pieces with front opening tops are recommended. Women's nylons must be removed before certain types of testing. Please avoid body lotions the day of the test.
- Wear comfortable shoes with soft soles.
- You may be asked to stop certain medications prior to your appointment, please check with your physician
- No caffeine or dairy products on day of test
- Stop eating and/or smoking 4 hours prior to test
- Bring list of medications.

If there are any questions about your appointment, please phone the Cardio-Respiratory Department with a minimum of 24 hours' notice: 705.325.2201 ext. 3151