NORTH BAY CARDIOLOGY

100 College Drive
North Bay, ON, P1B 8K9
Tel: 705-667-1076
Fax 705-995-3396
www.northbaycardiology.ca

Date of Referral:

Name:

Address:

City:

Postal Code:

Health Card Number (with version code)

D.O.B (yyyy/mm/dd)

Telephone (primary): Other (cell/work):

Referring Physician/Nurse Practitioner

Name: **Billing Number**:

Office Address:

Telephone: **Fax:**

REASON FOR REFERRAL *(Referrals with insufficient information may be returned)*

☐**Cardiology consultation requested.**

REASON FOR CONSULT:

☐Chest pain
☐Pre-syncope/Syncope
☐Palpitations
☐Heart Failure, "*does NOT meet CHF clinic referral criteria*"
☐Murmur
☐Cardiac risk factors, genetic
☐Other: _____

Diagnostic Testing:

☐12-Lead ECG
☐14-day Holter Monitor
☐72-hour Holter Monitor
☐Transthoracic Echocardiogram, *indication required*
  ☐with contrast
  ☐agitated saline bubble study

☐Consultation if *SIGNIFICANT ABNORMALITY*

INDICATION FOR TESTING

TRANSTHORACIC ECHOCARDIOGRAM (REQUIRED)

☐Suspected Heart Failure/Dyspnea
☐Murmur
☐Suspected Valve Disease
☐Prosthetic heart valve
☐Hypertension
☐Neurological Event
☐Chest pain
☐Pericardial disease
☐Arrythmia syndrome/syncope
☐Pulmonary disease/hypertension
☐Pre-procedure
☐OTHER _____

HOLTER (REQUIRED)

☐PALPITATIONS
☐PRE-SYNCOPE/SYNCOPE
☐SUSPECTED ARRHYTHMIA
☐STROKE
☐Other: _____

Referring provider SIGNATURE (Required) _____☐ NP/ ☐MD

*PLEASE FAX PREVIOUS TESTING RESULTS/REPORTS.