NORTH BAY CARDIOLOGY

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

All referrals must be for adults aged 18 years and older.

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:

☐ CARDIOLOGY CONSULTATION

Reason for Consult

- ☐ Chest pain
- ☐ Pre-syncope/Syncope
- ☐ Palpitations
- ☐ Arrythmia: ☐ known: _____ ☐ suspected
- ☐ Heart Failure, LVEF ____ or LVEF not known ☐
- ☐ Murmur/Valve disease
- ☐ Cardiac risk factors
- ☐ Other: _____

☐ CARDIAC TESTING

☐ TRANSTHORACIC ECHOCARDIOGRAM

- ☐ WITH CONTRAST
- ☐ BUBBLE STUDY

Reason for Echocardiogram (Required)

- ☐ Suspected Heart Failure/ Dyspnea
- ☐ Hypertension
- ☐ Syncope
- ☐ Chest pain
- ☐ Pulmonary disease
- ☐ Prosthetic heart valve
- ☐ Recent CABG/PCI
- ☐ Suspected Valve Disease
- ☐ Hypertension
- ☐ Pulmonary disease
- ☐ Pre-procedure/pre-operative
- ☐ OTHER _____

☐ CONSULT IF SIGNIFICANTLY ABNORMAL

HOLTER MONITOR/ECG

- ☐ 12 Lead ECG
- ☐ 48 Hour Holter ☐ 72 Hour Holter
- ☐ 14 Day Holter

Reason for Holter/ECG (Required)

- ☐ Pre-Syncope/Syncope
- ☐ Palpitations
- ☐ Chest pain
- ☐ Arrythmia assessment: ☐ known: _____
- ☐ Neurological Event

☐ CONSULT IF SIGNIFICANTLY ABNORMAL

☐ **24 HOUR AMBULATORY BLOOD PRESSURE MONITOR** (not covered by OHIP, cost is $40)

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

PLEASE ATTACH PREVIOUS TESTING & HEALTH HISTORY. INCOMPLETE REFERRALS WILL BE RETURNED