Cardiac Testing and Referral Requisition

Apex Diagnostic Services Inc.

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Testing & Consult Referrals

Patient Demographics / Label

Last Name: _____ Sex: F ☐ M ☐
First Name: _____
Address: _____
City: _____
Postal Code: _____
Phone Number: _____ Height: _____
D.O.B. _____ in/cm
Age: _____
HCN _____ Weight: _____
GP: lb/kg
Referring MD Signature:

Date:

Medications

☐ CCB ☐ Nitro Patch
☐ BB
Other: _____

MD Info:

Referring MD: _____
Billing No.: _____
CC:

Consult & Recommended Testing:

☐ Urgent ☐ Routine ☐ **TESTING ONLY**
☐ 1st Available Physician Requested Physician:

Patient History/Test Indication: Please indicate if any of the following exist.

☐ Greater than 10% on Framington Risk Score

☐ LBBB
☐ Afib
☐ CAD/MI
☐ CABG
☐ TIA/CVA
☐ Diabetes
☐ Hypertrophic Cardiomyopathy
☐ Moderate/Severe Asthma
☐ Unable to do treadmill

☐ Chest Pain
☐ Palpitations
☐ Syncope
☐ Shortness of Breath
☐ Hypertension
☐ Congestive Heart Failure

☐ Valvular Disease
☐ Valve Replacement : ☐ Mechanical ☐ Tissue ☐ AVR ☐ MVR
☐ Pacemaker: ☐ Single Chamber ☐ Dual Chamber ☐ ICD
☐ PCI: Artery if known: _____

Other: _____

Testing Available:

☐ Ambulatory Blood Pressure Monitor
☐ Treadmill Stress Test
☐ Stress Nuclear
☐ Holter Monitor
☐ Exercise Stress Echo
☐ Persantine Nuclear
☐ Echocardiogram
☐ Dobutamine Stress Echo
☐ MUGA Scan
☐ ECG

* Please advise your patient that ABP monitor is not paid by OHIP. Fee is $50.00 exact cash at time of service.
** Please be advised that OHIP no longer pays for routine pre-op or routine annual reassessment testing in asymptomatic patients as of January 1, 2013.
Please record symptoms or medical condition being evaluated.