HEALTHY HEART INSTITUTE

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Referral Form

Date:_____

-- Check All That Apply –

☐ **Stress Test with Cardiologist Consultation**
☐*1st Available, or* ☐*Specific Physician* _____

☐ **Consultation** ☐ Cardiologist ☐ Respirologist ☐ Internist ☐ Diabetes
☐*1st Available, or* ☐*Specific Physician(s)* _____

☐ **Echocardiogram**
☐*Book cardiology consultation if significant pathology is identified*
☐*Repeat Echo every ___ months*

☐ **Carotid Doppler**
☐ **ECG** (12-Lead)
☐ **Holter Monitor** (☐ 24h ☐ 48h)

☐ **PFT** ☐ *Repeat PFT every ___ months*
☐**Complete** (Spirometry pre/post β_2-agonist, lung volumes, DLCO)
☐**Partial** (Spirometry pre/post β_2-agonist, DLCO)

Referring Physician

Name: _____

Prac ID: _____ Specialty: _____

Phone: _____ Fax: _____

Family MD: _____

Cc Report to: _____

Patient

Last Name: _____

First Name: _____

City/Town: _____

PHN: _____ Gender_____

DOB: _____ Phone:_____

Height: _____ cm Weight: _____ kg

History/Indication:

MD Signature **X**_____