HEALTHY HEART INSTITUTE

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Referral Form

Date: _____

-- Check All That Apply –

☐ **Consult** ☐ Cardiologist ☐ Respirologist ☐ Internist
☐ 1st Available or ☐ specific physician _____

☐ **Stress Test** ☐ **With Cardiology Consult** ☐ 1st Available or ☐ specific physician _____
Type: ☐ Myocardial Perfusion ☐ ECG stress test **Stress Modality:** ☐ Exercise ☐ Pharmacologic
Please check all those that apply:
☐ DM ☐ Asthma ☐ Pacemaker ☐ ICD ☐ CABG ☐ PCA ☐ Chest Pain ☐ SOB ☐ Syncope ☐ Palpitations
☐ NPD / Orthopnea ☐ Low extremity edema / nocturia
Pre-Test likelihood of CAD? ☐ very low ☐ low ☐ intermediate ☐ high ☐ know CAD
See HHI Website for indications, contraindications and preparation for CEST https://www.hhi.life

☐ **Left Ventricular Systolic Function - MUGA**

☐ **Echocardiogram (TTE)** ☐ Repeat echo every ___ months
☐Book cardiology consultation if significant pathology is identified

☐ **Carotid Doppler**

☐ **ECG** (12-Lead) ☐ **Holter Monitor** ☐ 24h ☐ 48h ☐ 4 weeks

☐ **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 / NP

Name: _____

PRACID: _____ Specialty: _____

Phone: _____ Fax: _____

Cc Report to: _____

Patient

Last Name: _____ First: _____

PHN: _____ DOB (d/m/y): _____

Address: _____

Gender_____ Phone: _____

Height: _____ cm Weight: _____ kg

History:

Medications:

MD / NP Signature _____