

Patient Name:

Date of Birth (yyy/mm/dd):

Health Card #:

CR #:

Address:

Phone # Home:

Work:

Email:

ELECTROPHYSIOLOGY/CARDIOLOGY REQUISITION & REFERRAL

Referring Practitioner: _____

Referring Practitioner Signature: _____

Referring Practitioner Fax #: _____ Email: _____

Height: _____ cm Weight: _____ kg

Test required:

- Ambulatory BP
- Bicycle stress test
- CRT optimization
- Dobutamine stress echo
- Echocardiogram
- Electrocardiogram
- EP study
- Exercise stress echo
- Holter Monitor 48-hour 24-hour
- ICD implantation
- Inherited heart disease clinic and genetic testing
- Pacemaker implantation
- Pacemaker/ICD/ILR interrogation
- Provocative drug challenge (Long QT, CPVT, Brugada Syndrome)
- Signal average ECG
- Tilt table testing
- Transesophageal echocardiogram
- Treadmill Exercise Test (Bruce/Modified protocol)
- Other: _____

Clinical History (check appropriate box)

- Unknown
- Diagnosed Myocardial Infarction
- Possible Ischemia Infarction
- Pulmonary Disease
- Hypertension
- Palpitations or Syncope
- Predominant Mitral Stenosis
- Aortic Stenosis/Aortic or Mitral Regurgitation
- Congenital Heart Disease
- Pericarditis

Medications (check all appropriate boxes)

- Unknown
- None of the following
- Digitalis
- Quinidine or Procainamide or Amiodarone
- Antihypertensives
- Diuretics
- Beta Blockers
- Calcium Channel Blockers
- Other: _____

Clinical Information/reason(s) for test:

EP consultation required Yes No

Copy to Family Physician: Dr. _____