SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE
iCare

DEMOGRAPHIC LABEL

Outpatient Cardiology Referral Form

Phone: 705-759-3434-ext 7088
Fax: 705-759-3609

HEALTH CARD NUMBER _____
NAME _____
ADDRESS _____
PHONE _____

Refer to: ☐ 1st Available ☐ Specific Cardiologist_____

Urgency: ☐ Routine(4-6 weeks) ☐ Urgent (1-2 weeks) ☐ Emergent (physician to physician)

Reason(s) For Referral:

☐ Chest Pain
☐ Palpitations/Syncope/ Arrhythmia
☐ Valvular Disease
☐ Congenital
☐ Heart Failure
☐ Second Opinion
☐ Assessment prior to non-cardiac surgery
Surgery:_____
Planned OR:_____
☐ Other _____

Clinical Information:

_____
_____
_____
_____

Risk Factors:

☐ HTN ☐ Smoking ☐ Diabetes ☐ Prior Cardiac Surgery ☐ Atrial Fibrillation

Height _____
Weight _____

The following must be **complete or ordered** prior to referral:

☐ Bloodwork (CBC, Creatinine, A1C, Lipids)
☐ ECG
☐ Palpitations - Holter Monitor
☐ Chest Pain - MIBI or EST
☐ SOB- ECHO & PFT
☐ Medication List
☐ Pertinent Consults
☐ Other _____

Please note that cardiology referral may be sent back without the appropriate tests and/or information attached

Referring Physician: _____ OHIP#: _____

Signature: _____ Date: _____

Incomplete Form Returned **Date/time:** _____

Circled below are needed

Bloodwork ECG Holter Monitor & Strips MIBI or EST ECHO & PFT
Medication List Pertinent Consults Other_____