# REFERRAL

ALBERTA CARDIOLOGY & MEDICAL CONSULTANTS INC.

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## PATIENT INFORMATION

Label Here

## REFERRING PHYSICIAN

Date: _____

Physician Name: _____

Physician Address: _____

Physician Number: _____

Physician Signature: _____

Copies To: _____

## URGENT

☐ ASAP ☐ Urgent (within 2 weeks) ☐ Semi-Urgent (more than 2 weeks)

## CONSULT

Consultation Requested:

☐ Cardiology/Internal Medicine

☐ Internal Medicine

☐ CV Risk Management

☐ Other

Clinical Notes:

_____

_____

_____

_____

_____

_____

_____

☐ Active Medication List:

_____

OR

☐ Patient to Provide List

_____

## CARDIAC DIAGNOSTIC EXAMINATION

Myocardial Perfusion Imaging (MPI)

☐ Exercise MPI with consult

☐ Pharmacological MPI with consult

Does Your Patient Have:

| | | |
|---|---|---|
| Diabetes | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Pacemaker | ☐ Yes | ☐ No |
| ICD | ☐ Yes | ☐ No |
| CABG | ☐ Yes | ☐ No |

Height: _____ cm/in

Weight: _____ lb/kg

Patient Likelihood of CAD:

☐ Low ☐ Intermediate ☐ High

☐ Bubble Echocardiogram

☐ Echocardiogram

☐ Carotid Ultrasound

☐ Exercise Stress Test with consult

☐ Stress Echocardiogram (needs Cardiology consult)

☐ 24 Hour Holter Monitor

☐ 48 Hour Holter Monitor

☐ ECG - Electrocardiogram

☐ 24 Hour BP Monitor

Indications: Please check all that apply:

☐ Abnormal ECG

☐ CAD/CHF

☐ Post PCI

☐ F/U known stable CAD

☐ Abnormal Treadmill Stress Test

☐ Functional Significance Coronary Stenosis

☐ Murmur

☐ Chestpain

☐ Shortness of breath

☐ Palpitations/ Arrhythmias
(suspected/known history of arrhythmias)

☐ Edema / PND / Orthopnea

☐ Hypertension/Left Ventrical hypertrophy

☐ Pulmonary Hypertension

☐ Cardiovascular risk assessment
(i.e. plaque presence, carotid intimal medical thickness)

☐ Syncope / Presyncope / Vertigo / Dizziness

☐ Stroke / TIA

☐ Carotid bruit

☐ Follow-up of known carotid stenosis

☐ Post-surgical angiographic intervention follow-up

☐ Diabetes

☐ Hypo/Hyper Thyroid

☐ Iron deficiency Anemia (Iron Infusion)

☐ Fatty liver