

PATIENTS DEMOGRAPHICS

 Date

First Name	<input type="text"/>	Gender	<input type="text"/>	Address	<input type="text"/>
Last Name	<input type="text"/>	Home Phone	<input type="text"/>	Cell Phone	<input type="text"/>
Date of Birth	<input type="text"/>	Version Code	<input type="text"/>	Email Address	<input type="text"/>
Health Card Number	<input type="text"/>				

REASON FOR REFERRAL

- Consultation (Cardiology)
- Consultation (Internal Medicine)
- Hypertension & Cardiac Risk Reduction Clinic
- Video or Telemedicine Consult

PROVIDERS

- First Available

TESTS REQUIRED

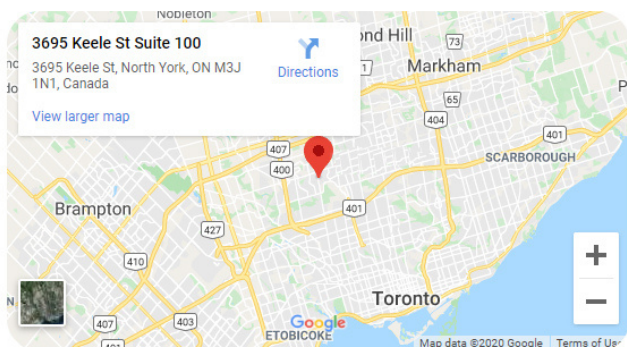
- Echocardiogram
- Treadmill Stress
- 24 HR ABP Monitor (not covered by OHIP)
- Stress Echo
- 12 Lead ECG
- Exercise Perfusion (performed at affiliated sites)
- Pharmacologic Perfusion (performed at affiliated sites)

HOLTER MONITOR (INDICATE ONE)

- 48 Hour
- 24 Hour
- 72 Hour
- 7 Days
- 14 Days

REFERRING PHYSICIAN

Physician Name	<input type="text"/>	OHIP Billing	<input type="text"/>
Phone Number	<input type="text"/>	Fax Number	<input type="text"/>
		Physician Email	<input type="text"/>



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