YORKVIEW CARDIOLOGY

REQUISITION FORM

PATIENTS DEMOGRAPHICS

Date

First Name | Gender | Address

Last Name | Home Phone | Cell Phone

Date of Birth | Version Code | Email Address

Health Card Number

REASON FOR REFERRAL

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

PROVIDERS

- First Available

TESTS REQUIRED

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

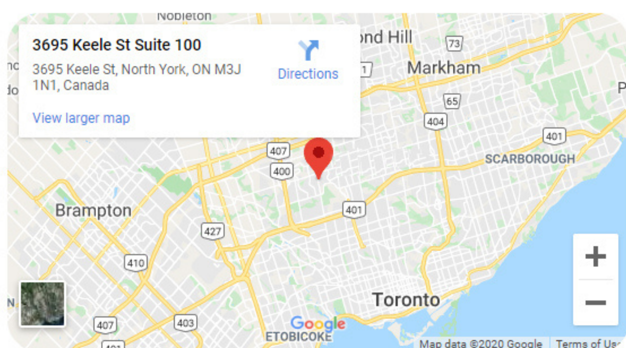
HOLTER MONITOR (INDICATE ONE)

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

REFERRING PHYSICIAN

Physician Name | OHIP Billing

Phone Number | Fax Number | Physician Email



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