



FAX COMPLETED FORM TO  
**877.718.0283**  
 CARDIO HEALTH WILL CONTACT THE  
 PATIENT TO SCHEDULE AN APPOINTMENT

**CARDIOLOGY REQUISITION FORM**

**CARDIOHEALTH.CA | TO BOOK AN APPOINTMENT CALL :1 877 718 2196 | 905 882 4848**

**PATIENT INFORMATION**

FIRST NAME \_\_\_\_\_  
 LAST NAME \_\_\_\_\_  
 HEALTH CARD NO \_\_\_\_\_  
 D.O.B \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 TEL NO \_\_\_\_\_

**REFERRING PHYSICIAN**

REFERRING MD \_\_\_\_\_  
 MD SIGNATURE \_\_\_\_\_  
 BILLING NO \_\_\_\_\_  
 FAX NO \_\_\_\_\_  
 ADDRESS \_\_\_\_\_

**PROCEDURES:**

URGENT

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>CARDIOLOGY CONSULTATION</b>        | <input type="checkbox"/> <b>TREADMILL STRESS ECHO/CONSULT</b> | <input type="checkbox"/> <b>NUCLEAR CARDIOLOGY</b>  |
| <input type="checkbox"/> <b>INTERNAL MEDICINE CONSULTATION</b> | <input type="checkbox"/> <b>CARDIAC REHAB</b>                 | <input type="checkbox"/> <b>IF TEST IS ABNORMAL</b> |
| <input type="checkbox"/> <b>ADULT ECHOCARDIOGRAM</b>           | <input type="checkbox"/> <b>24 HRS AMBULATORY BLOOD</b>       | PLEASE ARRANGE FOR A CONSULTATION                   |
| <input type="checkbox"/> <b>HOLTER 72 HOURS</b>                | <input type="checkbox"/> <b>PRESSURE MONITORING</b>           |   |
| <input type="checkbox"/> <b>ECG</b>                            | (NOT COVERED BY OHIP)   |   |

**CONSULTANTS CARDIOLOGY**

- |  |   |
|--|---|
| • Dr. Saul Miller<br>MD, FRCP (C)                    | • Dr. Eva Lonn<br>MD, FRCP (C)                        |
| • Dr. Ahmed Al-Riyami<br>MD, DABIM, FRCP (C)         | • Dr. Henry Onyegbule<br>MD                           |
| • Dr. Sachin Wadhawan<br>MD, FRCP (C)                | • Dr. Ganraj Kumar<br>MDCM, FRCPC, FACP               |
| • Dr. Joseph Zupnik<br>MD, CM, FRCP (C)              | • Dr. R.Padmanabhan Iyer<br>MD, FRCP (C), FACP, FCCP  |
| • Dr. Zahid Sardar<br>BSC, MD, FRCP (C), FACP        | • Dr. Sobia Zuberi<br>MD, FRCP (C)                    |
| • Dr. Majed Fiaani<br>MD, FRCP (C)                   | • Dr. Mohamed Ashif Majeed<br>MD                      |
| • Dr. Abdelwahab Arrazaghi<br>MD, FRCP (C)           | • Dr. Rubeena Khan<br>MD, MBBS, FRCP (C), (PEDIATRIC) |
| • Dr. Syed Faraz Masood<br>MD, FRCP (C)              | • Dr. Monika Spurek<br>MD, FRCP (C)                   |
| • DR. Syed Muhammed Najaf Ali Nadeem<br>MD, FRCP (C) | • Dr. Hourmazd Haghbayan<br>MD, FRCP (C)              |
| • Dr. Abdulaziz Ahmed Hashi<br>MD, FRCP (C)          | • Dr. Genevieve Gabra<br>MD, FRCP (C)                 |
| • Dr. Rahul Bhindi<br>MD, FRCP (C)                   |   |

**HISTORY/CLINICAL  
 INFORMATION :**

\_\_\_\_\_  
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**REASON FOR TEST**

- PALPITATION**  
 **CHEST PAIN**  
 **SOB**  
 **ABNORMAL ECG**  
 **DIZZINESS**  
 **HYPERTENSION**  
 **R/O CAD**  
 **OTHER** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CARDIOVASCULAR RISK REDUCTION PROGRAM**

**RISK FACTORS: (CHECK APPROPRIATE BOXES)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>AGE</b>             | <input type="checkbox"/> <b>OBESITY</b>           | <input type="checkbox"/> <b>POOR DIET</b>           |
| <input type="checkbox"/> <b>FAMILY HISTORY</b>  | <input type="checkbox"/> <b>DIABETES MELLITUS</b> | <input type="checkbox"/> <b>SEDENTARY LIFESTYLE</b> |
| <input type="checkbox"/> <b>ETHNICITY</b>       | <input type="checkbox"/> <b>HYPERTENSION</b>      | <input type="checkbox"/> <b>HIGH STRESS</b>         |
| <input type="checkbox"/> <b>SMOKING HISTORY</b> | <input type="checkbox"/> <b>DYSLIPIDEMIA</b>      | <input type="checkbox"/> <b>METABOLIC SYNDROME</b>  |

\*PLEASE BRING WITH YOU THIS REQUISITION FORM, YOUR HEALTH CARD AND YOUR LIST OF MEDICATIONS. THANK YOU FOR YOUR COOPERATION  
 HEAD OFFICE: Unit 101, 30 West Beaver Creek Rd, Richmond Hill, L4B 3K1, ON | info@cardiohealth.ca