



925 - 19<sup>TH</sup> Street South, Lethbridge, Alberta, Canada

## PATIENT INFORMATION

Name:		Birth Date: dd\ mm\ yyyy\	
Health Care Number:	Address:		
Phone:	City:	Province:	Postal Code:

## CARDIAC DIAGNOSTIC SERVICES

Please feel free to phone for an appointment or fax this completed form and we will contact the patient for you.

### SERVICE(S) REQUESTED:

- Transthoracic Echocardiogram (Regular Echo)**      Electrocardiogram (12-lead ECG/EKG)  
 24 Hour Holter Monitor with baseline ECG      Other: \_\_\_\_\_

*○ Please check to indicate NO baseline ECG required with this Holter request (recent baseline ECG must then accompany this form)*

Urgency:    ASAP      Within 2 weeks      Routine

### INDICATION(S)

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Chest Pain                 | <input type="checkbox"/> Heart Failure          | <input type="checkbox"/> Syncope/Presyncope | <input type="checkbox"/> Murmur           |
| <input type="checkbox"/> Abnormal ECG               | <input type="checkbox"/> Oedema/PND             | <input type="checkbox"/> Palpitations       | <input type="checkbox"/> Valvular Disease |
| <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Arrhythmia         | <input type="checkbox"/> Prosthetic Valve |
| <input type="checkbox"/> Left Ventricle Hypertrophy | <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Stroke/TIA         | <input type="checkbox"/> Endocarditis     |

## CLINICAL CARDIOLOGY REFERRALS

To avoid any possible delay with your referral please include full patient demographics, relevant patient documents and reports with the referral letter.

\*Includes Cardiology Consultation unless otherwise indicated.

- Consultation                                      Phone Advice  
  
 Dobutamine Stress Echocardiogram (DSE)\*  
     *○ Please check if NO cardiology consultation requested with DSE*  
  
 Exercise Stress Test - Treadmill (EST)\*  
     *○ Please check if NO cardiology consultation requested with EST*  
  
 Transoesophageal Echocardiogram (TEE)\*  
     *○ Please check if NO cardiology consultation requested with TEE*

Clinical summary or questions to be answered:

## REFERRING PHYSICIAN INFORMATION

Name:			
PRAC ID:	Referral Date: dd\ mm\ yyyy\	Phone:	
Address:			Fax:
City:	Province:	Postal Code:	Copies To:

Date of Exam: \_\_\_\_\_

Time: \_\_\_\_\_

# IMPORTANT INFORMATION FOR PATIENTS

## For Echocardiogram, ECG and Holter appointments:

- You may eat, drink, and take your usual medications prior to your appointment.
- You may brush your teeth and wear deodorant.
- Please ensure you have clean, dry skin and NO body oils, lotions or powders.
- Please bring your Provincial Health Care Card with you to your appointment



## OUR ADDRESS

925 - 19<sup>TH</sup> Street South  
Lethbridge, Alberta  
T1J 3H4



## OUR LOCAL LETHBRIDGE NUMBERS

PHONE: 587.425.3246  
FAX: 587.425.3247