



CARDIOLOGY REFERRAL

PHONE: (587) 425-3246

FAX: (587) 425-3247

LETHBRIDGE NUMBER

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925 - 19TH 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)

- To be performed at Lethbridge, AB
- To be performed at Pincher Creek, AB
- Limited Transthoracic Echocardiogram
- Electrocardiogram (12-lead ECG/EKG)

Urgency: Urgent Routine

- 24 Hour Holter Monitor with baseline ECG
- 24 Hour Holter Monitor without baseline ECG
- Other: _____

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.

- Consultation
- Phone Advice
- Dobutamine Stress Echocardiogram (DSE)
 - Please indicate if a clinical consultation is also requestedDSE requires a recent (within one year) baseline transthoracic echocardiogram (TTE); to ensure clinically and technically appropriate. Please ensure baseline TTE is available prior to referral for DSE.
- Exercise Stress Test - Treadmill (EST)
 - Please indicate if a clinical consultation is also requested
- Transoesophageal Echocardiogram (TEE)
 - Please indicate if a clinical consultation is also requested

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 Transthoracic Echocardiogram (Regular Echo), 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 - 19TH Street South
Lethbridge, Alberta T1J 3H4



OUR LOCAL LETHBRIDGE NUMBERS

PHONE: 587.425.3246
FAX: 587.425.3247