CHINOOK CARDIOLOGY

CARDIOLOGY REFERRAL

PHONE: (587) 425-3246 LETHBRIDGE NUMBER
FAX: (587) 425-3247 LETHBRIDGE NUMBER
1605 9TH Avenue South, Lethbridge, Alberta, Canada
Hours of Operation: 8:00am - 5:00pm, Monday-Friday
(Excluding Statutory Holidays)

PATIENT INFORMATION

Name:		Birth Date: dd\ mmm\ yyyy\	
Health Care Number:	☐ Allergy to latex	Gender: ☐ Pediatric	
Phone:	Address:		
Cell 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:

Urgency: ☐ STAT ☐ Urgent ☐ Routine ☐ Specific Timeframe: _____

Location: ○ Lethbridge *All ages welcome ○ Pincher Creek *Adult Regular Transthoracic Echocardiogram only

☐ Transthoracic Echocardiogram (Regular ultrasound of the heart)

☐ Holter monitor with baseline ECG

☐ Holter monitor without baseline ECG (Please attach recent ECG)

Requested number of hours to record:
○ 24 ○ 36 ○ 48 ○ 72 ○ Other: _____ (Maximum 1 week)

☐ Limited Echocardiogram (Reassess/follow up from a recent echocardiogram) *Please attach previous report

☐ 24 hour Ambulatory Blood Pressure monitor *Adult referrals only

☐ Electrocardiogram (12-lead ECG/EKG)

☐ Other: _____

Indication(s) or Clinical summary / question(s) to be answered:

☐ Chest Pain ☐ Heart Failure ☐ Syncope/Presyncope ☐ Murmur
☐ Abnormal ECG ☐ Oedema/PND ☐ Palpitations ☐ Valvular Disease
☐ Hypertension ☐ Shortness of Breath ☐ Arrhythmia ☐ Prosthetic Valve
☐ Left Ventricle Hypertrophy ☐ Pulmonary Hypertension ☐ Stroke/TIA ☐ Endocarditis

☐ Other questions to be answered:

CLINICAL CARDIOLOGY REFERRALS**

***For clinical cardiology referrals, please send a referral letter and any relevant reports and documents.*

☐ Consultation

☐ Phone Advice

☐ Dobutamine Stress Echocardiogram (DSE)*
○ *Please indicate if a clinical consultation is also requested*

*DSE & ESE require a recent (within six months) baseline transthoracic echocardiogram (TTE); to ensure clinically and technically appropriate. Please ensure baseline TTE is available prior to DSE or ESE.

☐ Exercise Stress Test - Treadmill (EST)
○ *Please indicate if a clinical consultation is also requested*

☐ Transesophageal Echocardiogram (TEE)
○ *Please indicate if a clinical consultation is also requested*

☐ Exercise Stress Echocardiogram (ESE)*
○ *Please indicate if a clinical consultation is also requested*

REFERRING PHYSICIAN INFORMATION

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

**Incomplete referrals may result in delays of the patient care.*

DATE OF EXAM: **TIME:**

Important Information for Patients

Instructions

- Please bring your Provincial Health Card with you to your appointment

For ALL appointments, please come with clean, dry skin

- Preferably NO lotions, oils or powders on the chest (You may wear deodorant)
- Monitors will need to be returned by the designated time (Dropbox open 24 hrs)
- Monitors MUST be kept dry – sweat/exercise are fine***
- Blood Pressure monitors – Wearing a loose, short sleeve shirt is preferable

OUR ADDRESS

1605 9 Avenue South
Lethbridge, Alberta T1J 1W2

—CHINOOK—
CARDIOLOGY

OUR LOCAL LETHBRIDGE NUMBERS

PHONE: 587.425.3246
FAX: 587.425.3247

Digital download of our referral form is available on our website: **www.chinookcardiology.com**