



CARDIOLOGY REFERRAL

PHONE: (587) 425-3246

FAX: (587) 425-3247

LETHBRIDGE NUMBER

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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:	<input type="checkbox"/> Allergy to latex	Gender:	<input type="checkbox"/> 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) Limited Echocardiogram
(Reassess/followup from a recent echocardiogram)
*Please attach previous report
- Holter monitor with baseline ECG Holter monitor without baseline ECG
(Please attach recent ECG)
- 24 hour Ambulatory Blood Pressure monitor
*Adult referrals only
- Electrocardiogram (12-lead ECG/EKG)
- Other: _____
- Requested number of hours to record:
 24 36 48 72 Other: _____ (Maximum 1 week)

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

- | | | | |
|---|---|---|---|
| <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 |
- Other questions to be answered:

CLINICAL CARDIOLOGY REFERRALS**

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

- | | |
|--|---|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Exercise Stress Test - Treadmill (EST)
<input type="radio"/> Please indicate if a clinical consultation is also requested |
| <input type="checkbox"/> Phone Advice | <input type="checkbox"/> Transesophageal Echocardiogram (TEE)
<input type="radio"/> Please indicate if a clinical consultation is also requested |
| <input type="checkbox"/> Dobutamine Stress Echocardiogram (DSE)*
<input type="radio"/> Please indicate if a clinical consultation is also requested | <input type="checkbox"/> Exercise Stress Echocardiogram (ESE)*
<input type="radio"/> 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.

REFERRING PHYSICIAN INFORMATION

Name:			
PRAC ID:	Referral Date: dd\ mm\ 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



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