# CARDIOVASCULAR INVESTIGATION UNIT REFERRAL FORM

Cardiovascular Investigation Unit
St. Joseph's Hospital; B3-030
268 Grosvenor St.
London, ON N6A 4V2
Telephone: 519 646-6000 ext.64221
Fax: 519 646-629

**PATIENT INFORMATION**

Surname: _____ Given Name: _____
Date of birth: _____ Sex: M F Health card number: _____
Address: _____ City: _____
Postal Code: _____ Home Phone: _____ Alternate: _____
Date of referral (YYYY/MM/DD/): _____ PIN# or J#: _____

**REFERRING PHYSICIAN INFORMATION**

Name: (please print) _____ Physician Number: _____
Address: _____ City: _____
Postal Code: _____Phone: _____ Fax: _____
Email: _____
Signature: _____
Family Doctor (if not ordering Physician):_____

Reason for referral (PLEASE select from our List of Indications)
Other (if necessary):_____

**Test:**

- ☐ Echocardiogram (2D)
- ☐ Saline Bubble Study
- ☐ Electrocardiogram
- ☐ Holter Monitor 48 hour
- ☐ Holter Monitor 24 hour
- ☐ Exercise Stress Test
- ☐ Research Electrocardiogram

**Indication (s):**

- ☐ New murmur
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Syncope
- ☐ Arrhythmia
- ☐ Valve Prosthesis
- ☐ Re-assess Stenosis
- ☐ Re-assess Regurgitation
- ☐ Suspected/Re-assess CHF
- ☐ Suspected/Re-assess Pericardial effusion
- ☐ Suspected/Re-assess Cardiomyopathy
- ☐ Suspected/Re-assess pulmonary hypertension
- ☐ R/O Cardiac source of stroke/TIA

**History:**

- ☐ Myocardial Infarction
- ☐ Coronary Artery disease
- ☐ Diabetes
- ☐ Hypertension
- ☐ Other_____

**Priority Status**: ☐ Urgent ☐ Semi-Urgent ☐ Routine

Clinic Use Only

PLEASE INFORM YOUR PATIENT TO ARRIVE 15 MINUTES PRIOR TO THEIR APPOINTMENT

Appointment Date: _____ Appointment Time: _____

Please advise your patient to review St. Joseph's website for more information regarding their visit with us, including directional information and parking instructions: http://www.sjhc.london.on.ca/cardiovascular