CARDIOVASCULAR INVESTIGATION UNIT REFERRAL FORM

Cardiovascular Investigation Unit
St. Joseph's Hospital
Zone B, Level 3, B3-030
268 Grosvenor St.
London, ON N6A 4V2
Telephone: 519 646-6019
Fax: 519 646-6292

PATIENT INFORMATION

Surname: _____ Given Name:_____
Date of birth:_____ Sex: M F Health card number:_____
Address:_____City:_____
Postal Code:_____ Does patient reside in a nursing home? ☐ YES ☐ NO
Home Phone:_____ Alternate:_____
Date of referral (YYYY/M/D):_____ 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 Exam/ Clinical History:

_____
_____

- ☐ Echocardiogram (2D)
- ☐ Echocardiogram + Saline Bubble Study
- ☐ Electrocardiogram
- ☐ Research Electrocardiogram
- ☐ Holter Monitor *An ECG will be performed, if there is not a recent (less than 1 year) test online.
  - ☐ 24 hour
  - ☐ 48 hour
  - ☐ 72 hour
- ☐ Exercise Stress Test *Where possible, performed as cardiopulmonary exercise stress test.
- ☐ Cardiopulmonary Exercise Stress Test

Does patient require assistance for transfer?

- ☐ Yes
  - ☐ Non-weight bearing
  - ☐ Partial weight bearing
  - ☐ Pivot transfer
  - ☐ Lift transfer
- ☐ No

PLEASE INFORM YOUR PATIENT OF THE FOLLOWING INFORMATION REGARDING THEIR APPOINTMENT

Appointment Date:_____ Appointment Time:_____

Please inform your patient they must arrive 20 minutes prior to their appointment.

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