ASPIRE CARDIOLOGY

CARDIOLOGY REQUISITION FORM

3780 14th Avenue, Suite 311 and 314
Markham, ON. L3R 4B7 | Tel: 416-503-8282

☐ **URGENT** ☐ **ROUTINE**

Date of Referral: _____

PATIENT INFORMATION: (affix label if available)

Name: _____ Date of Birth (MM/DD/YYYY): _____ Gender: _____

Address: _____ OHIP Number: _____

Phone Number: _____ Alternate Phone Number: _____

Email Address: _____

REASON FOR REFERRAL:

☐ Cardiology Consultation ☐ Exercise Stress Test - GXT ☐ 12 Lead ECG

☐ Echocardiogram ☐ Holter Monitoring ☐ Consult if Result is Abnormal

CLINICAL HISTORY/INDICATIONS: (please attach and relevant/current reports)

_____

_____

_____

_____

REFERRING PHYSICIAN: _____ Billing Number: _____

Address: _____ Tel: _____ Fax Number: _____

Completed forms are to be returned via **fax: 416-503-1495** or **email: admin@aspirecardiology.com**.
Our office will contact the patient directly to schedule an appointment.