



# 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:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cardiology Consultation | <input type="checkbox"/> Exercise Stress Test - GXT | <input type="checkbox"/> 12 Lead ECG                   |
| <input type="checkbox"/> Echocardiogram          | <input type="checkbox"/> Holter Monitoring          | <input type="checkbox"/> Consult if Result is Abnormal |
| <input type="checkbox"/> Stress Echocardiogram   |   |  |

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

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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.