AV DIAGNOSTICS
Cardiology Associates

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# REFERRAL FORM

## PATIENT INFORMATION

NAME _____

D.O.B. _____

HEALTH CARD # _____

TELEPHONE # _____

## APPOINTMENT

DATE _____

TIME _____

☐ URGENT

☐ INFORM REFERRING PHYSICIAN WITH SCHEDULED TIME

## SERVICES

☐ CARDIOLOGY CONSULTATION
☐ ECHOCARDIOGRAM
☐ STRESS ECHO
☐ STRESS TEST

☐ HOLTER MONITOR ☐ 24 HR ☐ 48 HR ☐ 72 HR ☐ 7 DAYS ☐ 14 DAYS
☐ LOOP/EVENT RECORDER ☐ 14 DAYS ☐ 30 DAYS
☐ AMBULATORY BP MONITOR ☐ 24 HR ☐ 48 HR
☐ ECG

☐ ADD CONTRAST TO ECHO OR STRESS ECHO
☐ BOOK A CONSULTATION IF TEST RESULTS ARE ABNORMAL

*Please forward for Consults: Previous ECG, blood work, and prior cardiac investigation results*

## INDICATIONS / CLINICAL INFORMATION

_____
_____
_____
_____
_____
_____
_____
_____

☐ ABNORMAL ECG
☐ ABNORMAL GXT
☐ ARRHYTHMIA / A. FIB.
☐ CHEST PAIN / ACS
☐ CARDIAC MASSES
☐ CARDIAC RISK FACTORS
☐ CARDIOMYOPATHY
☐ DIZZINESS
☐ EMBOLIC EVENTS
☐ ENDOCARDITIS
☐ HEART MURMUR
☐ HIGH BP / HTN
☐ HISTORY / SUSPECTED MVP
☐ HISTORY OF CAD
☐ HISTORY OF CHF
☐ HISTORY OF MI / STROKE
☐ PALPITATIONS
☐ PEDAL EDEMA
☐ PERICARDIAL DISEASE
☐ PRE-CARDIOVERSION
☐ PROSTHETIC VALVE/S
☐ PULMONARY HTN/DISEASE
☐ SHORTNESS OF BREATH
☐ SYNCOPE
☐ THORACIC AO DISEASE
☐ VALVULAR DISEASE

**DATE** _____ **MD** _____