Referral Form

UNIT-2, 725 ARLINGTON PARK PLACE
KINGSTON, ON, K7M 7E4
TEL: 613-547-5458 Fax: 613-547-6406
Email: CONTACT@APEXHEARTCENTRE.COM

Physician/ NP Name: _____

Office Address: _____

Tel: _____

Fax: _____

MOH Billing #: _____

Copy Report to: _____

Signature: _____

Date (DD/MM/YY): _____

PATIENT INFORMATION

Name: _____

Address: _____

Tel: (H) _____

(C) _____

Date of Birth: _____ ☐ M ☐ F

Health Card: _____ VN: _____

Attach past medical history, updated medication list, recent discharge summary and relevant testing for any consultation requests. Referrals missing this information will delay patient booking.

☐ **Urgent** ☐ **Semi Urgent** ☐ **Elective**

Reason for Referral:

Cardiology Consultation:

☐ **First Available**

☐ **Dr. Margaret Cases, MD, FRCPC**
Cardiology & Echocardiography

☐ **Dr. Tina Zhu, MD, FRCPC**
Cardiology & Echocardiography

Cardiac Testing:

☐ 12-lead ECG
☐ Resting ECHO
☐ Holter: ☐ 48h ☐ 72hr ☐ 14-days
☐ 24hr Ambulatory BP monitor (75$ surcharge – not covered under OHIP)

Stress Testing:

☐ Consult if ischemia positive
☐ Treadmill Exercise Stress Test
☐ Treadmill Stress ECHO
☐ Bike Stress ECHO
☐ Dobutamine Stress ECHO

Subspecialty Clinic Referral:

Post-Revascularization Clinic

Date of cardiac event (DD/MM/YYYY): _____

Post-revasc Echo done? ☐ Y ☐ N LVEF: ____%

Heart Failure Clinic

Date of last ECHO (DD/MM/YYYY): _____ LVEF: ____%

Recent hospitalization? ☐ Y ☐ N

Date of discharge (DD/MM/YYYY): _____

Current Wait Times:

Test	Urgent	Semi Urgent	Elective
Consultation	2-6 weeks	6-10 weeks	6-10 months
Resting Echo	1-3 weeks	3-5 weeks	2-4 months
Stress / Dobutamine Echo	1-3 weeks	3-5 weeks	2-3 months
Bike Echo / Stress Test	1-4 weeks	3-6 weeks	2-3 months
Holter	2-3 weeks	3-6 weeks	3-4 months
ABPM	1-2 weeks	2-4 weeks	2-3 months