



PARIS
Heart Clinic

www.parisheartclinic.com

CARDIOLOGY REQUISITION

Paris Heart Clinic
25 Curtis Ave. N., Unit 105
Paris, ON N3L 3V3

Tel: 226-806-5833
Fax: 855-794-0966

PATIENT INFORMATION

NAME: _____ D.O.B: _____
ADDRESS: _____
PHONE #: _____ OHIP#: _____ WEIGHT: _____

APPOINTMENT

DATE: _____
TIME: _____
*** PLEASE ARRIVE 10 MIN. BEFORE YOUR APPT. TIME.
*48 HOURS NOTICE FOR CANCELLATIONS.**

CLINICAL INFORMATION _____ _____ _____ _____ _____	REFERRING PHYSICIAN _____ ADDRESS _____ TEL/FAX _____ OHIP BILLING # _____ SIGNATURE _____ COPY TO _____
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CARDIOLOGY

12-LEAD ELECTROCARDIOGRAM

STRESS TEST (EXERCISE ONLY - GXT)

ECHOCARDIOGRAM (Colour Doppler) Please select one of the following indications:

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Murmur
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Palpitations/Arrhythmias
<input type="checkbox"/> Syncope	<input type="checkbox"/> Congestive Heart Failure

Other: _____

Holter Monitoring

<input type="checkbox"/> 24 hrs.	<input type="checkbox"/> 48 hrs.	<input type="checkbox"/> 72 hrs.	<input type="checkbox"/> Other: _____
<input type="checkbox"/> LOOP/Cardiac Event (2 weeks)	<input type="checkbox"/> 24 hr BP Monitor (\$80.00 cash only - Not covered by OHIP)		

CARDIOLOGY CONSULTATION

Consultation Requested **URGENT**

First available appointment

Dr. _____

Consult if test result positive / abnormal