Cambridge Cardiac Care Centre

Dr. A. S. Pandey, Laboratory Director
Laboratory Referral Requisition

Patient Name: _____ D.O.B: (d/m/y) _____

Patient's Address: _____

Home Phone #: _____ Day Time Phone #: _____ Cell Phone #: _____

Health Card #/ VC: _____ Sex: _____ Wt: _____ Ht: _____

Test Required	Routine	Urgent
2-D Echocardiogram	☐	☐
3-D Echocardiogram	☐	☐
Contrast Echocardiogram	☐	☐
Stress Echocardiogram	☐	☐
Stress test	☐	☐
Holter Monitor	☐ 24 hr ☐ 48 hr ☐ 14 day	☐ 24 hr ☐ 48 hr ☐ 14 day
14 Day Loop Recorder	☐	☐
Spirometry	☐	☐
12 Lead ECG	☐	☐
Ambulatory BP monitor *	☐	☐

Clinic Options	Routine	Urgent
Rapid Access AFIB Clinic	☐	☐
Rapid Access CHF Clinic	☐	☐
Cardiac Rehabilitation	☐	☐

Is a consultation with Cardiologist required? ☐ Yes ☐ No ☐ Dr. C. Way (Pediatric Cardiologist)

Indication for the referral: _____

_____

Referring Physician: _____ Signature: _____

Copies to: _____

*this test is not covered by OHIP- there is a charge to the patient. Some drug plans cover this test.
The lab has a ***48 hour*** cancellation policy. Please inform the patient.

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Prevention. Dectection. Therapy