

Referral Office: 2891 Sunridge Way NE, Calgary, AB T1Y 7K7 | Phone: 403 571 8640 | Fax: 403 776 7681 | totalcardiology.ca

Patient Information

Last Name: _____ First Name: _____ Height: _____ cm
 Address: _____ City: _____ Prov: _____ Weight: _____ kg
 Postal: _____ Phone (home): _____ Mobile: _____ Email: _____
 Date of Birth: (dd/mm/yyyy) _____ PHN: _____ Male Female Other: _____

Diagnostic Testing

- Myocardial Perfusion Imaging Stress Test** (Off Meds* On meds^)
 Exercise Pharmacologic
- Exercise Stress Test (No Imaging)** (Off Meds* On meds^)
* In patients without a history of CAD, a stress test is typically done off anti-anginal meds (e.g., beta-blockers, calcium channel blockers, nitrates) if deemed safe.
 ^ In patients with established CAD, in whom you are evaluating new symptoms, suggest continuing anti-ischemics.
- Echocardiogram**
 Bubble Contrast Strain
- Carotid Doppler**
- Holter Monitor (1-Day) + ECG**
- ECG** (Sunridge location only)

Indication(s) for Referral:

- Chest pain or suspected angina
- Dyspnea
- Edema
- Valvular heart abnormalities or murmur
- Pericardial abnormalities
- Adult congenital heart disease
- Carotid bruit
- TIA/stroke
- Syncope
- Pre-syncope
- Palpitations
- Atrial fibrillation/atrial flutter
- Dysrhythmia
- Abnormal cardiac test (e.g., ECG)
- Pre-op risk assessment for non-CV surgery
- Other – please explain in relevant history section below.

Consultation

- Routine/non-urgent** **Urgent cardiology consultation[†]**
- To refer to a specific cardiologist, please fax referral to their office. Wait times vary by office. Visit totalcardiology.ca for physician directory. Patient may be assessed by internal medicine specialist or nurse practitioner.
- [†] Referrals will be reviewed to determine if they meet criteria for urgent consultation. Patients who do not meet the criteria will be triaged to the next available appointment. Please visit our website for a list of urgent referral criteria.

Relevant History/Additional Information (please include relevant reports with referral)

Referrer Information

Referrer Name: _____ Prac ID: _____ Phone: _____ Fax: _____
 CC Reports to: Family MD: _____ Other: _____
 Location: ER/Urgent care Clinic/Office Referrer Signature: _____