LONDON CARDIAC INSTITUTE

Referral to:
LONDON CARDIAC INSTITUTE
302-256 Pall Mall Street, London ON N6A 5P6
Telephone: 519-645-0146 / **Fax:** 519-645-1584

DATE OF REFERRAL: (yyyy/mm/dd)		
PATIENT NAME:		☐ IN PATIENT ☐ OUT PATIENT
ADDRESS:		TEL: Home: Work: Cell:
CITY:	POSTAL CODE:	
D.O.B.: (yy/mm/dd)	HEALTH CARD #:	Version Code:

REFERRING PHYSICIAN:

NAME:	BILLING NUMBER:
ADDRESS:	
TELEPHONE:	FAX:

DIAGNOSIS / REASON FOR REFERRAL:

Is this an URGENT request? ☐ Yes ☐ No

REQUESTED SERVICE: *****PLEASE FAX ANY EXISITING RHYTHM STRIPS*****

- ☐ Consultation – General Cardiology
- ☐ Consultation – Arrhythmia Service
- ☐ Echocardiogram ☐ Bubble Study ☐ Contrast
- ☐ 24 hr Holter ☐ 48 hr Holter
- ☐ Loop Event Recorder – Wear for ______ # weeks
- ☐ Non-Looping Event Recorder - Wear for ______ # weeks
- ☐ 12 Lead ECG
- ☐ Stress Test (Consult included)
- ☐ Cardioversion
- ☐ Consultation / Tilt Table Test
- ☐ Pacemaker (Please complete Pacemaker Referral Form)
- ☐ ICD (Please complete ICD Referral Form)
- ☐ Lead Extraction (Please complete Lead Extraction Referral Form)
- ☐ Other:

OTHER PERTINENT INFORMATION (including medications):

________________________________ Referring Physician's Signature

________________________________ Date

PLEASE FAX ANY *EXISTING* RHYTHM STRIPS, CARDIAC INVESTIGATIONS (ECGs, Stress Test, Echo, etc), CLINICAL NOTES, DISCHARGE SUMMARIES ALONG WITH THE COMPLETED REFERRAL FORM.

FAX TO: 519-645-1584

Revised: 2013 December

PLEASE VISIT OUR WEBSITE FOR MORE INFORMATION:
www.londoncardiac.ca