ST. JOSEPH'S HEALTH CENTRE | TORONTO

CARDIOLOGY IMAGING CONSULTATION

St. Joseph's Health Centre
East Wing, Room 1E-132
30 The Queensway, Toronto ON

Phone Line: 416-530-6325
Fax Line: 416-530-6702

Name: _____
Male ☐ Female ☐
MRN : _____
DOB: _____
Address: _____
_____
Telephone: _____
OHIP #: _____

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

☐ Emergency Department Patient ☐ Inpatient ☐ Urgent Outpatient (within 72 hours)

Cardiology Consultation Requested ☐ YES ☐ NO

ECHOCARDIOGRAPHY

☐ Transthoracic Echocardiogram (TTE)
☐ Exercise Stress Echocardiogram
☐ Bubble (Agitated Saline) Echocardiogram

The following require a Cardiology Consult
☐ Transesophageal Echocardiogram (TEE)
☐ LV Contrast (Definity ®) Study

ELECTROCARDIOGRAPHY

☐ Electrocardiogram (ECG)
☐ Holter Monitor ☐ 24 hour ☐ 48 hour
☐ Exercise Treadmill (GXT)

☐ 14 Day Event (Loop) Recorder
☐ Ambulatory Blood Pressure Monitor (ABPM)
(ABPM) –Patient will be charged $55.00

NUCLEAR CARDIOLOGY (Fax Requisition to DI ext. 6060)

☐ Exercise Myocardial Perfusion
☐ Persantine Myocardial Perfusion
☐ Dobutamine Myocardial Perfusion

☐ Ejection Fraction Imaging
☐ Myocardial Viability Imaging

CLINICAL HISTORY

ADDITIONAL INFORMATION

☐ Falls Risk ☐ Lifting Device Required ☐ Patient with Restraints (must be accompanied)

Isolation Precautions: ☐ Contact ☐ Droplet ☐ Airborne

Does Patient Consent to Appointment Information Being Disclosed in a Telephone Message? ☐ Yes ☐ No

Is Patient Able to Come in on Short Notice? ☐ Yes ☐ No

Contact Telephone Number: _____

REQUESTING PHYSICIAN

Address: _____ City: _____ Postal Code: _____

Telephone Number: _____ Fax: _____ CPSO #: _____

Copy to: _____ MD (Physician's Printed Name)

DATE/TIME	SIGNATURE	PRINT NAME
DD / Month / YYYY ___ ___ : ___ ___ h		