ASPIRE CARDIOLOGY

CARDIOLOGY REQUISITION FORM

3780 14th Avenue, Suite 311 and 314
Markham, ON. L3R 4B7 | Tel: 416-503-8282

☐ **URGENT** ☐ **ROUTINE**

Date of Referral: ______________________

PATIENT INFORMATION: (affix label if available)

Name: ______________________ Date of Birth (MM/DD/YYYY): ______________ Gender: _____

Address: ______________________________ OHIP Number: ___________________________

Phone Number: ____________________ Alternate Phone Number: ________________________

Email Address: ______________________________

REASON FOR REFERRAL:

☐ Cardiology Consultation ☐ Exercise Stress Test - GXT ☐ 12 Lead ECG

☐ Echocardiogram ☐ Holter Monitoring ☐ Consult if Result is Abnormal

CLINICAL HISTORY/INDICATIONS: (please attach and relevant/current reports)

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REFERRING PHYSICIAN: ___________________________ Billing Number: _______________

Address: _________________________ Tel: ______________ Fax Number: _______________

Completed forms are to be returned via **fax: 416-503-1495** or **email: info@aspirecardiology.com**. Our office will contact the patient directly to schedule an appointment.