Western Cardiology Associates

301-740 Hillside Avenue
Victoria BC, V8T 1Z4
Phone: (250) 595-1551 Fax: (250) 595-6793

REFERRAL DATE:______________REFERRING DR:____________________

PATIENT NAME: ____

PHN: _________________________DOB:_______________________________

GENDER: M F Needs assistance with mobility

HOME PHONE:______________________CELL PHONE:__________________

WORK PHONE:______________________EMAIL:______________________

USE ALTERNATIVE CONTACT:_____________________________________

ADDRESS: ____

MEDICATIONS: ____

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TREADMILL REQUEST: (ONLY patients with **NO KNOWN** coronary artery disease.)

☆12 LEAD ECG LESS THAN 3 MONTHS OLD MUST BE ATTACHED☆

Dx: ____

BP: ________
Family history of CVA disease
Abnormal lipids (please attach copy)
Atypical chest discomfort/pain:_________________________________

HOLTER REQUEST: (for patients having symptoms occurring 2 or more times weekly)

Palpitations
AFib
Pacer
Syncope
Medication evaluation – medication:_____________________________
Other symptoms due to arrhythmia:______________________________

CONSULTATION REQUEST: **PRE-OP: Date\Type of Surgery____________________**

Cardiologist requested: ____

Please forward us the following records so that we can process your referral:

Holter Monitors Full Disclosure Interpreted portion only
Treadmill Tests Full Disclosure Interpreted portion only
Any Electrocardiograms (ECG's) Specifically showing arrhythmia
Radiology MIBI scans CT scans Ejection Fractions MRI scans
Ultrasound Echocardiograms (Echo) Carotid/Venous
Blood work (current within 1 year)
Last hospital visit notes/consults
Specialist consults
Other ____

Please update our office if the urgency of your patient's referral changes.