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Affiliated with
Joseph Brant Hospital
William Osler Health system

CARDIOVASCULAR ASSESSMENT REFERRAL

PATIENT'S DEMOGRAPHICS (attach label)

Full Name (first & last)
DOB (DD/MM/YYYY)
Gender Female or Male
Phone no.
Health Card no.

APPROPRIATE REFERRAL INDICATION (MUST SELECT ONE)

- Chest pain, Palpitations/ Arrhythmia, Syncope/ Dizziness, Abnormal ECG, Stroke / TIA, Murmur/ Valve disease, Shortness of breath / Heart Failure, CAD / Post PCI / Post CABG, Hypertension/ Hypertensive heart disease, Claudication / Peripheral vascular disease, Intermediate/ High Framingham risk score, High risk family history for heart disease, Exercise prescription, Pre-Operative Cardiac risk assessment

OTHER INDICATION / CLINICAL INFO

Blank lines for other indications and clinical information.

IMPORTANT INFO

ALL ABNORMAL TESTS WILL BE SEEN IN CONSULTATION AUTOMATICALLY

PLEASE ATTACH PRIOR CARDIAC REPORTS RELEVANT TO THIS REFERRAL

PRIORITY

- Urgent (<1 wk), Semi Urgent (1-2 wks), Elective (>2 wks)
Note: contact our cardiologist if earlier appointment required.

CLINIC TESTING

- 12 Lead ECG, Holter Monitor (48h, 72h, 1-2 wks), Echocardiogram (Contrast, Bubble Study), Exercise Stress Test (treadmill), Exercise Stress Echocardiogram, Ambulatory Blood Pressure Monitor (not covered by OHIP)

AFFILIATED HOSPITAL TESTING

- Transesophageal Echo, Nuclear Cardiac Scan (MIBI), Coronary angiogram, Cardiac MRI, Coronary CT Angiography, Coronary Calcium Score

REFERRING MD (PRINT CLEARLY)

Full name, Billing no., Phone no., Fax no., Signature, Date (DD/MM/YYYY)

ALL PATIENTS WILL BE SEEN IN CARDIOLOGY CONSULTATION, TICK ADJACENT BOX IF ONLY DIAGNOSTIC TESTING REQUIRED.