

Request for Cardiology Consultation

Patient's Details:

First Name Last Name Sex

Date of Birth Phone P.H.N

Address

Diagnosis / Clinical History:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Chest pain / IHD |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Cardiomegaly |
| <input type="checkbox"/> LV Function Assessment | <input type="checkbox"/> Syncope | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Native Valve Assessment | <input type="checkbox"/> Prosthetic Valves | <input type="checkbox"/> Edema | <input type="checkbox"/> Pericardial Disease |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Abnormal ECG | <input type="checkbox"/> Palpitations |
| | | | <input type="checkbox"/> Preoperative Assessment |

Notes

Ref. MD Copy to

Date Appointment Date

For **URGENT** consultations, please contact 306-757-2478

Please fax this form to 306-585-3993 or mail it to the address shown below. You may also e-mail this form to: contact@echo.ly