CORE
Heart Health Center

REFERRAL FORM
CARDIOLOGY

Please complete this form in block capitals in black ink.

Patient Name	Last		First	Date of Birth	(M / F)
Insurance	Company	Policy #		Group #	
Address					
Telephone	Home	Work	Cell	Other	
E-mail Address					

REFERRING DOCTORS DETAILS

GP NAME:	TEL:
PRACTICE:	
ADDRESS:	POSTAL CODE:
EMAIL:	FAX:

TYPE OF REFERRAL

❑ Fasting Cardiac Risk Profile	❑ Resting 12 Lead ECG
❑ Follow-up Consultation	❑ Stress Testing
❑ Other	❑ Holter Monitoring
If other (Please state)	

CURRENT MEDICATIONS

ALLERGIES

PLEASE ATTACH MOST RECENT LABS		PLEASE ATTACH LAST	
❑ Fasting Cardiac Risk Profile	❑ Hemoglobin A1C	❑ ECG	❑ Stress Test
❑ CBC	❑ Chemistry Profile	❑ Echo	
❑ EDP	❑ Coag Screen		

REFERRING DOCTORS NOTE - SIGNATURE

Note:	
Sign:	Date: