



**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
OHIP Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Copies to: (Physicians Name): \_\_\_\_\_  
Appointment Date and Time: \_\_\_\_\_

**REASON FOR REFERRAL**

- |   |   |  |                                       |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Abnormal ECG                   | <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Dizziness/Syncope              | <input type="checkbox"/> Other: (specify)<br>_____ |                                       |
| <input type="checkbox"/> Pre-Operative Evaluation | <input type="checkbox"/> Cardiovascular Risk Assessment |  |                                       |

**CARDIOLOGY**

- Consult (If not already seen by a Cardiologist)

**STRESS TESTING**

- Graded Exercise Stress Test
- Exercise Stress Echocardiogram (ECHO)
- Stress ECHO with Dobutamine Weight: \_\_\_\_\_

**ECHOCARDIOGRAPHY**

- ECHO
- ECHO with Contrast
- ECHO with Saline (Bubble) Study
- Transesophageal Echocardiogram (TEE)

**NUCLEAR IMAGING**

Myocardial Perfusion Scan:

- Graded Exercise Stress Test– Weight: \_\_\_\_\_ Height: \_\_\_\_\_
- Persantine Stress Test– Weight: \_\_\_\_\_ Height: \_\_\_\_\_
- Dobutamine Stress Test– Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**ARRHYTHMIA ASSESSMENT**

- Electrocardiography (ECG)
- Pacemaker follow-up
- ICD follow-up

**AMBULATORY MONITORING**

- 24-Hour Holter Monitoring
- 48-Hour Holter Monitoring
- Continuous Loop Recorder
- Ambulatory Blood Pressure Monitoring (ABPM) (24 hours) (\$50.00 charge applied)

Physician's Name: \_\_\_\_\_  
(Please print)

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
(DD/MM/YYYY)





**PATIENT INSTRUCTIONS**

- Bring valid health card as required by the Ministry of Health.
- Bring all current medications or list of them. Continue all your medications, unless instructed otherwise by your physician.
- Bring this form with you. Please bring reading glasses if required to read and sign the consent form.
- No lotion or powder on skin.
- Bring comfortable walking shoes and wear clothing suitable for exercising.
- If you need assistance with translation at your appointment, it is helpful to bring someone with you who can provide translation. If we are notified in advance, we can often arrange to have translation services available for you.

**MYOCARDIAL PERFUSION SCAN**

1. Do not consume any caffeinated or decaffeinated products for at least **12 hours** prior to the start of test (this includes no tea, coffee, decaffeinated products, chocolate, soda pop or medications containing caffeine).
2. Nothing to eat or drink (except sips of water for medications) for **3 hours** prior to the test.
3. The MIBI test consists of **two parts**. The **first part** lasts approximately one and a half hours. The patient can then leave but must return **three hours later** to complete **the second part** of the test (which is also one and a half hours). Total test time is approximately **six hours**.

**Special Considerations:**

- Medications such as aminophylline, theophylline or similar medications must be stopped 48 hours prior to the test as recommended by your physician.
- For patients who are Insulin Dependent Diabetics, you may have a light breakfast (e.g. juice and cereal)

**CARDIAC STRESS TESTING**

1. No caffeine products on the day of testing.
2. For stress ECHO with Dobutamine, someone must accompany you, as a sedative may be given.

**TRANSESOPHAGEAL ECHOCARDIOGRAM (TEE)**

1. **NOTHING** to eat or drink after **midnight** prior to your study (your morning medications **CAN** be taken with sips of water). Someone must accompany you, as a sedative may be given.

**HOW TO GET TO HOSPITAL**

The Cardiac Diagnostics Department is located on the 1st floor in the East Wing next to Pharmacy.

We require 24 hours advance notice of any changes to booked appointments. To cancel or reschedule your appointment, please call 905–683–2320 ext. 1168

**Lakeridge Health Ajax Pickering  
580 Harwood Ave S,  
Ajax, ON L1S 2J4**

