

DIAGNOSTIC SERVICE REQUISITION

PATIENT INFORMATION (attach patient label)

Patient Name: _____ M F
 ULI: _____ DOB: _____
 Address: _____ Postal Code: _____
 City, Province: _____ Home phone: _____
 Email: _____

Referral Date: _____

URGENT TESTING REQUESTED

PULMONARY DIAGNOSTIC SERVICES

- Pulmonary Function Test (PFT)
 - Include Smoking Cessation
 - Include Medication/Inhaler Education & Review
- Spirometry Only
 - Pediatric Spirometry & Education

CLINICAL SERVICES

- Cardiovascular Assessment & Consultation
Provided by Internist and/or Cardiologist based on patient complexity

CARDIAC DIAGNOSTIC SERVICES

- Nuclear Cardiology Studies
MUST include recent ECG
- Exercise Stress Test
MUST include recent ECG
- ECG
- Holter Monitor
 - 48 hour
 - Other: _____
- ABPM (24 hour)
- Echocardiogram (including GLS)
- Carotid Doppler

Medical History & Notes: *For cardiac stress testing, please note any patient respiratory or mobility concerns below.*

Pre-test Probability of CAD: Low Intermediate High

Is your patient currently taking any: Beta Blockers Calcium Channel Blockers N/A

REFERRING PHYSICIAN INFORMATION

Referring Clinic: _____
 Phone: _____ Fax: _____
 Physician Name: _____
 PRAC ID#: _____

Referring Physician Signature: _____