



**Ajax Site:**  
 102-300 Rossland Road East, 1st Floor,  
 Ajax, ON, L1Z 0M1  
 Tel: 905.426.3111  
 Fax: 905.426.7138

**Oshawa Site:**  
 3-475 Bond St W,  
 Oshawa, ON, L1J 2M2  
 Tel: 905.447.6528  
 Fax: 905.225.6528

DurhamCardiology.ca

PATIENT INFORMATION	PHYSICIAN INFORMATION
Last Name: _____ First Name: _____	Referring Physician: _____
Address: _____	Address: _____
City: _____ Prov.: _____ Postal Code: _____	Phone: _____ Fax: _____
Phone: _____ Cell: _____	Billing #: _____
E-mail: _____ DOB: _____ Age: _____	Copy to: _____
Health Card #: _____ Gender: _____	Signature: _____

**Cardiac Consultation:**  1st Available  Dr. B. Ayach  Dr. N. Saukila

**Cardiac Surgery Consultation:**  Dr. G. Bisleri  Dr. C. Tarola

**Urgency:**  Routine (4+ wks)  Semi-Urgent (2-4 wks)  Urgent /Chest Pain (< 2 wks)

**Indication:**

- |                                     |  |                                     |
|-------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> CAD        | <input type="checkbox"/> Syncope/Dizziness   | <input type="checkbox"/> CHF        |
| <input type="checkbox"/> Murmur     | <input type="checkbox"/> Valvular Disease    | <input type="checkbox"/> Stroke     |

**Other Information:** \_\_\_\_\_  
 \_\_\_\_\_

**CARDIOLOGY DIAGNOSTIC TESTING**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Exercise Stress Test (GXT) | <input type="checkbox"/> 2D Echocardiogram (TTE) | <input type="checkbox"/> 12-Lead ECG                 |
| <input type="checkbox"/> Exercise Stress Echo*      | <input type="checkbox"/> Pediatric Echo (TTE)    | <input type="checkbox"/> Transesophageal Echo (TEE)* |

**CARDIOLOGY MONITORING**

**Holter:**  48 hrs  72 hrs  7Days

**NUCLEAR CARDIOLOGY**

**Myocardial Perfusion Imaging (MPI)**

- Exercise SPECT\*  Persantine SPECT\*

**Ventricular Function**

- MUGA (with ejection fraction) SPECT\*

**Please indicate:** Height: \_\_\_\_\_ Weight: \_\_\_\_\_

All critical findings will be reviewed in consultation / \* At Lakeridge Health or affiliated centres