Burlington: 200-1100 Walkers line
Mississauga: 102-5602 tenth line W
North Bay: 304-1950 Algonquin Av
Sudbury: 9-2140 Regent St.
Timmins: 117-38 Pine St. N.
Cochrane: 4-233 Eighth St
Iroquois Falls: 58A Anson Drive.
Temiskaming Shore: 240 Shepherdson Rd

Horizon Cardiology Centre

Download this form from:
https://horizoncardiology.ca/

Phone: +1 (289)-505-1605
Fax: +1 (905)-225-6537
info@horizoncardiology.ca

Request For Cardiac Examination

Patient Information (Affix Label if Available)

Full Name:		Gender:	Height:	Weight:
Address:	Street # & Name:	City:		Postal Code:
Health Card #:		Cell Phone		
Date Of Birth:	dd/mm/yy: Age:	Family Physician:		

Clinical Indication

Clinical Hx:-

◯ Chest Pain	◯ SOB	◯ Palpitation	◯ Syncope	◯ Murmur	◯ CVA/TIA
◯ CAD	◯ CHF	◯ Arrythmias	◯ LL swelling	◯ Others:	

Examination(s) Requested	Patient's Cardiologist
◯ **Echocardiography** (regular comprehensive TTE). **Add:-** ◯ **Bubble** Study ◯ **Strain** Study	◯ **N/A (First Available)**
◯ **Contrast** Echocardiography.	
◯ **Pediatric Echo**	◯ **Dr. Anthony Main**
◯ Exercise **Stress Echocardiography (SE)**	◯ **Dr. Atilio Costa Vitali**
◯ **Ischemic Heart Disease Protocol**	◯ **Dr. Brian Wong**
◯ Diastolic Dysfunction Protocol	◯ **Dr. Djilali Hanzal**
◯ Cardiomyopathies Protocol	◯ **Dr. Grama Ravi**
◯ Native Valve Disease Protocol	◯ **Dr. Mohamed Ibrahim**
	◯ **Dr. Mohamed Shurrab**
◯ **Exercise Stress ECG (GXT)**	◯ **Dr. Raed Abu Shama**
◯ **Rest** 12-Lead **ECG.**	◯ **Dr. Roger Labonte**
◯ **Holter** Monitoring: ◯ 72 hrs ◯ 1 week ◯ 2 Weeks ◯ Others:	
◯ **In-Clinic** / Walk-In (9 am – 12 pm and 1 pm to 4 pm)	**Pediatric Cardiology Team**
◯ **By-Mail** (No extra fee)	◯ **Dr. Yousef Etoom**
◯ **At-Home** (No extra fee)	◯ **Dr. Wald Rachel**
	Level III Echo Cardiologists
◯ **BP Monitoring** (24 Hours) (Not insured by OHIP)	◯ **Dr. Mohamed Ibrahim**
	◯ **Dr. Djilali Hanzal**
	Electrophysiology Team
	◯ **Dr. Raed Abu Shama**
◯ **Urgent**	◯ **Dr. Atilio Costa Vitali**
	◯ **Dr. Mohamed Shurrab**

Referring Physician Information (Stamp Label if Available)

Referring Physician:	Tel:
Physician's Signature:	Fax:
	Copy to:
Billing Provider #:	Note:
Date: dd/mm/yy:	