



London Cardiac Institute

Referral to:
LONDON CARDIAC INSTITUTE
 302-256 Pall Mall Street, London ON N6A 5P5
 Telephone: 519-645-0146 / Fax: 519-645-1584

DATE OF REFERRAL: (yyyy/mm/dd)		
PATIENT NAME:		<input type="checkbox"/> IN PATIENT <input type="checkbox"/> OUT PATIENT
ADDRESS:		TEL: Home: Work: Cell:
CITY:	POSTAL CODE:	
D.O.B.: (yy/mm/dd)	HEALTH CARD #:	Version Code:
REFERRING PHYSICIAN:		
NAME:		BILLING NUMBER:
ADDRESS:		
TELEPHONE:		FAX:
DIAGNOSIS / REASON FOR REFERRAL:		
REQUESTED SERVICE: ***PLEASE FAX ANY EXISTING RHYTHM STRIPS***		
<input type="checkbox"/> Consultation – General Cardiology	<input type="checkbox"/> Urgent	<input type="checkbox"/> Stress Test (Consult included)
<input type="checkbox"/> Consultation – Arrhythmia Service		<input type="checkbox"/> Cardioversion
<input type="checkbox"/> Echocardiogram <input type="checkbox"/> Bubble Study		<input type="checkbox"/> Tilt Table Test
<input type="checkbox"/> 24 hr Holter <input type="checkbox"/> 48 hr Holter		<input type="checkbox"/> Pacemaker (Please complete Pacemaker Referral Form)
<input type="checkbox"/> Loop Event Recorder		<input type="checkbox"/> ICD (Please complete ICD Referral Form)
<input type="checkbox"/> Non-Looping Event Recorder		<input type="checkbox"/> Lead Extraction (Please complete Lead Extraction Referral Form)
<input type="checkbox"/> 12 Lead ECG		<input type="checkbox"/> Other:
OTHER PERTINENT INFORMATION (including medications):		
_____		_____
Referring Physician's Signature		Date
<p>PLEASE FAX ANY <i>EXISTING</i> RHYTHM STRIPS, CARDIAC INVESTIGATIONS (ECGs, Stress Test, Echo, etc), CLINICAL NOTES, DISCHARGE SUMMARIES ALONG WITH THE COMPLETED REFERRAL FORM.</p> <p>FAX TO: 519-645-1584</p>		

PLEASE VISIT OUR WEBSITE FOR MORE INFORMATION:
www.londoncardiac.ca