



# London Cardiac Institute

## Urgent Cardiology Clinic

### Patient Referral Form

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#### *Patient Information*

Name: .....  
Birthday: .....  
Address: .....  
City: ..... Prov: .....  
Postal Code: ..... Phone: .....

#### *Referring Physician Information*

Name: .....  
eMail: .....  
Phone: .....  
Fax: .....  
OHIP Billing No: .....

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#### *Reason for Referral:*

*Please append copies of relevant history / physical exam and any pertinent cardiac investigations (ECG, Echo, etc.)*

*Date:* \_\_\_\_\_

*Physician Signature:* \_\_\_\_\_

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**London Cardiac Institute**  
**256 Pall Mall Street Suite 302, London, Ontario, N6A 5P6**  
**519-645-0146 Fax 519-645-1584**

**Email: [office@londoncardiac.ca](mailto:office@londoncardiac.ca) Web Page: <http://www.londoncardiac.ca>**

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NOTE: The patient will be sent an appointment directly and a copy will also be emailed / faxed to the referring physician if the physician contact information is provided.