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<p><b>For Patients:</b></p> <p><b>Contrast Echocardiogram:</b> This test takes <b>45 minutes</b> to <b>1 hour</b>, and you will have an intravenous inserted into your arm. No special preparation is required.</p> <p><b>*Bring a current list of any medications you are taking.</b></p> <p><b>Exercise Stress Echocardiogram:</b> This test takes <b>45 minutes to 1 hour</b>. No special preparation is required.</p> <p><b>*Bring a current list of medications you are taking.</b></p> <p><b>*Wear loose fitting, comfortable clothing and running shoes.</b></p> <p><b>Holter Monitoring:</b> This test takes <b>15 minutes</b> for Holter hookup. You may be required to wear the monitor anywhere from 24 hours to 14 days.</p> <p><b>*Wear a loose-fitting top.</b></p> <p><b>*You cannot shower with the monitor on or get the monitor wet.</b></p> <p><b>*We recommend you shower prior to coming.</b></p> <p><b>*Refrain from wearing lotions or perfumes.</b></p>	<p><b>Patient Demographics</b></p>									
	<p>Last Name: _____ First Name: _____</p> <p>DOB: _____ HCN: _____ Version Code: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Address: _____</p> <p>Phone: _____ Cell: _____ Email: _____</p> <p>Alternate Contact Name: _____ Phone: _____</p>									
	<p><b>Referring Physician</b> <span style="float: right;"><input type="checkbox"/> URGENT</span></p>									
	<p>Referred By: _____ Billing: _____</p> <p>Telephone: _____ Fax: _____</p> <p>Signature: _____ Address: _____</p>									
	<p><b>Procedure</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Cardiology Consultation</td> <td><input type="checkbox"/> ECG</td> </tr> <tr> <td><input type="checkbox"/> Internal Medicine Consultation</td> <td><input type="checkbox"/> Exercise Stress Test (GXT)</td> </tr> <tr> <td><input type="checkbox"/> Echocardiography</td> <td><input type="checkbox"/> Holter Monitoring <input type="checkbox"/> 48 Hours <input type="checkbox"/> 72 Hours</td> </tr> <tr> <td><input type="checkbox"/> Stress Echocardiogram</td> <td><input type="checkbox"/> Ambulatory Blood Pressure Test (fee \$75)</td> </tr> </table>		<input type="checkbox"/> Cardiology Consultation	<input type="checkbox"/> ECG	<input type="checkbox"/> Internal Medicine Consultation	<input type="checkbox"/> Exercise Stress Test (GXT)	<input type="checkbox"/> Echocardiography	<input type="checkbox"/> Holter Monitoring <input type="checkbox"/> 48 Hours <input type="checkbox"/> 72 Hours	<input type="checkbox"/> Stress Echocardiogram	<input type="checkbox"/> Ambulatory Blood Pressure Test (fee \$75)
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	<p><b>Reason For Referral</b></p> <p><input type="checkbox"/> Abnormal ECG</p> <p><input type="checkbox"/> Arrhythmia</p> <p><input type="checkbox"/> CAD Assessment</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> High Risk Factors</p> <p><input type="checkbox"/> Pericardial Effusion</p> <p><input type="checkbox"/> Dyspnea</p> <p><input type="checkbox"/> OTHER: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Risk Factors</b></p> <p><input type="checkbox"/> AGE</p> <p><input type="checkbox"/> FAMILY HISTORY</p> <p><input type="checkbox"/> DIABETES</p> <p><input type="checkbox"/> SMOKING HISTORY</p> <p><input type="checkbox"/> OBESITY</p> <p><input type="checkbox"/> HYPERTENSION</p> <p><input type="checkbox"/> DYSLIPIDEMIA</p> <p><input type="checkbox"/> POOR DIET</p> <p><input type="checkbox"/> HIGH STRESS</p> <p><input type="checkbox"/> OTHER: _____</p> <p>_____</p> <p>_____</p>								

Please note that late cancellation or no-show fees may apply.