CharlesClinic
Heart Care

Cardiology Referral

Patient's Name: _____

Address: _____

_____ DOB: ____ /____ /____ Male / Female

Phone: _____ Mobile: _____

Please perform the following:

- ☐ Urgent Consultation
- ☐ Consultation Only
- ☐ Consultation and any Testing as Appropriate
- ☐ Echocardiogram
- ☐ Exercise Stress Echo
- ☐ Holter Monitor
- ☐ Ambulatory Blood Pressure Monitor
- ☐ ECG

Clinical History (Please include previous cardiac related operative reports and any special medications or special requirements e.g. reduced mobility etc.)

_____

_____

_____

_____

_____

_____

Referring Doctor: _____

Address: _____

Phone: _____ Fax: _____

Email: _____ Signature: _____

Date: ____ /____ / 20____ Provider No: _____ Copy To: _____

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Together we lead the way with Committed Compassionate Care