



VICTORIA
CARDIAC CARE

Victoria Cardiac Care
REFERRAL FORM

101-2475 McDougall Ave, Windsor ON, N8X 3N9

Phone: 226-773-1413

info@victoriacardiac.ca

Fax: 226-773-0951

Patient Information (affix patient label here)

Name	Gender	DOB
Address		Phone Number

Health Card _____

Referring MD and Billing #: _____

Family MD and Billing #: _____

Date of Referral: _____

**AVAILABLE SERVICE(S): PLEASE CHECK
APPLICABLE BOX**

PREOP

**PREOP
CONSULTATION**

CARDIAC

- EKG
- CARDIAC
CONSULTATION**
- STRESS ECHO
- ECHO
- EXERCISE STRESS
TEST
- **HEART MONITOR:**
 - 24hr 48hr
 - 72hr 2 week
- EKG
- PEDIATRIC ECHO**

Reason for Referral:

Please send all pertinent information and attach:

- Labwork Diagnostic/Imaging results Consult Note(s) Other information