



# REFERRAL FORM

510 Southdale Rd. E., Suite 104  
 London, ON N6E 0B2  
 Phone: (226) 777-0902  
 Fax: (226) 777-0419

### 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: \_\_\_\_\_

MD Signature: \_\_\_\_\_

### 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
- 24hr Blood Pressure Monitor \$80 charge

Urgent

Priority

Routine

Reason for Referral:

Supervised by:  
**Dr. N. Mikail Huq**  
 MD, FRCPC, FACC, MBA  
 Consultant Cardiologist

APPT: \_\_\_\_\_

Please send all pertinent information and attach:

Labwork

Diagnostic/Imaging results

Consult Note(s)

Other information

\*Consult if deemed necessary by a Cardiologist