

Fax completed form to 403.352.7601

For further assistance/information, call 403.352.7600

(Requests will be processed Monday to Friday 0715-1430 excluding statutory holidays)

Name		PHN
Home Phone	Work Phone	Cell Phone
Urgency based upon risk assessment <i>(Emergent patients will need physician to physician contact. Patient/referring location will be contacted by a Nurse Navigator from the Cardiology Department to arrange appointment(s). If this is not suitable, please call the Internist/Cardiologist directly.)</i>		
Note current approximate wait times		
<input type="checkbox"/> Urgent 1-2 weeks <input type="checkbox"/> Semi-Urgent 2-4 weeks <i>(If routine, send to a specialist office. If less than 72 hours, contact Cardiology on call - Red Deer)</i>		
Requested Test	<input type="checkbox"/> Stress Test/Consultation <input type="checkbox"/> Other <i>(specify)</i> _____	
Patient Instructions		
<ul style="list-style-type: none"> ■ Ensure patient has stress test preparation sheet prior to test <i>(DTHR01-20034/1204)</i> ■ Request that patient bring a list of current medications with them to the appointment 		
Send copies of all available documentation		
<ul style="list-style-type: none"> ■ History, Labs <i>(lipids, electrolytes, urea/creatinine, glucose and CBC)</i>, CXR if relevant ■ Previous Stress, Echo, Thallium, Angiogram, Consults, Discharge and OR reports ■ ECG's or arrhythmia strips 		
Internist <i>(The stress test will be booked with the first available internist unless a preferred internist is indicated. Indicating a preferred internist may affect wait time.)</i> <input type="checkbox"/> First available internist <input type="checkbox"/> Preferred or usual internist <i>(specify)</i> _____	Check all that apply <input type="checkbox"/> Typical Chest Pain <input type="checkbox"/> Atypical Chest Pain <input type="checkbox"/> Abnormal rest ECG and/or monitoring strips <i>(fax copy to Cardiology)</i> <input type="checkbox"/> Cardiac Markers done <i>(fax copy of results to Cardiology)</i> <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Difficulty walking <i>(describe)</i> _____ _____	
Comments <i>(please elaborate on urgency and need for required test)</i> _____ _____ _____ _____		
Referring Physician	Signature	Date of Referral <i>(yyyy-Mon-dd)</i>