

Dynacare.ca | 877.718.2196 | Home Office: 416.264.4795

PATIENT INFORMATION

FIRST NAME: _____
LAST NAME: _____
HEALTH CARD NO: _____
D.O.B: _____
CITY: _____
TEL NO: _____

REFERRING PHYSICIAN

REFERRING MD: _____
MD SIGNATURE: _____
BILLING NO: _____
FAX NO: _____
ADDRESS: _____

PROCEDURES

- | | | |
|--|--|---|
| <input type="checkbox"/> ADULT ECHO | <input type="checkbox"/> 72 H HOLTER | <input type="checkbox"/> LOOP RECORDER |
| <input type="checkbox"/> STRESS ECHO | <input type="checkbox"/> 48 H HOLTER | <input type="checkbox"/> ECG |
| <input type="checkbox"/> CARDIOLOGY CONSULTATION | <input type="checkbox"/> STRESS TEST | <input type="checkbox"/> AMBULATORY BLOOD PRESSURE
(Not covered by OHIP) |
| <input type="checkbox"/> INTERNAL MEDICINE
CONSULTATION | <input type="checkbox"/> IF TEST IS ABNORMAL,
please arrange for a consultation | |

HISTORY/CLINICAL INFORMATION:

REASON FOR TEST

- PALPITATION
 CHEST PAIN
 SOB
 ABNORMAL ECG
 DIZZINESS
 OTHER

CARDIOVASCULAR RISK REDUCTION PROGRAM

RISK FACTORS: (Check Appropriate Boxes)

- | | | |
|--|--|--|
| <input type="checkbox"/> Age | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> High Stress |
| <input type="checkbox"/> Family History | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Inactive Coronary Artery Disease* |
| <input type="checkbox"/> Ethnicity | <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Inactive Peripheral Artery Disease* |
| <input type="checkbox"/> Smoking History | <input type="checkbox"/> Poor Diet | <input type="checkbox"/> Inactive Cerebrovascular Disease* |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Sedentary Lifestyle | <input type="checkbox"/> Metabolic Syndrome |

*Controlled symptoms, no surgical intervention in the past year or planned for the coming year