Alberta Health Services

Outpatient Pre-Registration Referral
Cardiac Diagnostics

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown	

This referral must be accompanied with a clinic note.

For more information on criteria and where to send the referral visit www.albertareferraldirectory.ca

Referring Clinic Information	Date Booking Request Received *(dd-Mon-yyyy)*

Appointment Date *(dd-Mon-yyyy)*	Time *(hh:mm)*	Height *(cm)*	Weight *(kg)*

Electrodiagnostics

☐ Electrocardiogram *(ECG)*
☐ Signal Averaging ECG *(ACH & FMC only)*
Indication for test _____

Exercise Stress Test

☐ Treadmill Stress Test
☐ Test to be Supervised by Cardiologist /Internal Medicine Physician *(specify physician)* _____
Indication for test _____

Ambulatory Monitoring

☐ Holter Monitor ☐ 24 Hour or ☐ 48 Hour
Pacemaker Model Lower Rate _____ Upper Rate _____
☐ Event Recorder ☐ 1 week ☐ 2 week ☐ Other _____
☐ Blood Pressure Monitor *(RGH & SHC only)*
Indication for test _____

Echocardiography ***(Note for PLC only Congenital Heart Patients)***

☐ Previous Echo Report attached
☐ Transthoracic Echocardiogram *(specify)* ☐ Complete ☐ Limited

Special Procedures *(Cardiologist approval is required)*

☐ Right Ventricular Biopsy (ultrasound guidance)
☐ Pericardiocentesis (ultrasound guidance)
☐ Contrast Echocardiogram
☐ Exercise Stress Echocardiogram
☐ Treadmill ☐ Bike
☐ Pharmacological (Dobutamine) Stress Echo
☐ Bubble Study Echocardiogram

Indication for test _____

☐ Transesophageal Echocardiogram (TEE) ***(complete the mandatory questions below, or referral will be returned)***

Is patient on CPAP? ☐ Yes ☐ No
Clinical Indication *(reason for exam)* _____
Patient's sedation requirement ☐ Conscious Sedation ☐ General Anesthesia
History of esophageal or gastric disease? *(i.e. varices, tumor, stricture or dilatation)* ☐ Yes ☐ No
History of Cirrhosis? ☐ Yes ☐ No
Does the patient have any additional conditions? *(dysphagia, thrombocytopenia, supplemental oxygen, laryngeal abnormalities, anticoagulants/antiplatelets, obstruction sleep apnea)* ☐ Yes ☐ No
If yes, explain _____
Is patient able to give informed consent? ☐ Yes ☐ No

Patient History/Medication

Ordering/Referring Physician Name	Signature	Date *(dd-Mon-yyyy)*