Alberta Health Services

Cardiac EASE Clinic Referral

Please fax this form **and ECG tracing** to the Cardiac EASE Clinic - 780.407.1091

Date *(yyyy-mon-dd)*	PHN	UAH
Patient Name	☐ Male ☐ Female	Date of Birth *(yyyy-Mon-dd)*
Address		Postal Code
Phone (home)	Phone (business)	

Reason for Referral

☐ Atrial Fibrillation
☐ Palpitations
☐ Valve Disease
☐ Congestive Heart Failure (Shortness of Breath)
☐ Chest Pain
☐ Other (specify) _____

Medical History

Current Medications

Name	Dose	Name	Dose

An ECG tracing within the last 3 months is required as part of cardiac care planning for your patient. This referal will not be processed without an ECG.

☐ **ECG** ☐ **Include all cardiac test results**

Referring Physician	Pracid ID
Address	Postal Code
Phone	Fax
Signature	