Outpatient Pre-Registration (Referral) Information
Cardiac Diagnostics

**Important** - This referral *must be accompanied* with a clinic note.

- Alberta Childrens Hospital (ACH) Fax 403-955-7621 Phone 403-955-7858
- Foothills Medical Center (FMC) 403-944-2016 403-944-1507
- Peter Lougheed Hospital (PLC) 403-250-9539 403-943-4565
- RockyView General Hospital (RGH) 403-943-3336 403-943-3713
- South Health Campus (SHC) 403-956-2645 403-956-2605

**Electrodiagnostics**

- Electrocardiogram (ECG)
- Signal Averaging ECG *(ACH & FMC only)*

**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)*

- Transthoracic Echocardiogram *(complete)*
  - Previous Echo Report attached
- Transesophageal Echocardiogram (TEE)
  - Yes  No
- Right Ventricular Biopsy *(ultrasound guidance)*
- Pericardiocentesis *(ultrasound guidance)*
- Contrast Echocardiogram
  - Indication for Test ______________________

**Patient History/Medication**

**Name of Referring/Ordering Physician** *(print)*

**Signature**

**Date** (yyyy-Mon-dd)

**Research Information** *(if applicable)*

**Name of Study**

**Ethics ID Number**

**Site**

- TBCC
- Other