Outpatient Pre-Registration Referral
Cardiac Diagnostics

This referral must be accompanied with a clinic note.

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

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<th>Referring Clinic Information</th>
<th>Date Booking Request Received (dd-Mon-yyyy)</th>
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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 □ 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 (specify) □ Complete □ Limited
- Previous Echo Report attached

Special Procedures (Cardiologist approval is required)
- Right Ventricular Biopsy (ultrasound guidance)
- Pericardiocentesis (ultrasound guidance)
- Contrast Echocardiogram
- Exercise Stress Echocardiogram
- 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)