The Heart CLINIC
HEart Assessment Rehabilitation & Treatment

Juda Habot MD, FRCPC

Codsell Medical

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TO BOOK AN APPOINTMENT:

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PATIENT INFORMATION

NAME: _____ ☐ M ☐ F

HEALTH #: _____ **VERSION CODE:** ____ **DATE OF BIRTH:** _____

CARDIOLOGY CONSULTATION

REASON: _____

CARDIOLOGY PROCEDURES

- ☐ ECHOCARDIOGRAM
- ☐ TREADMILL STRESS ECHO
- ☐ BICYCLE STRESS ECHO
- ☐ TREADMILL STRESS TEST
- ☐ BICYCLE STRESS TEST
- ☐ 24 HRS. HOLTER MONITOR
- ☐ 48 HRS. HOLTER MONITOR
- ☐ 72 HRS. HOLTER MONITOR
- ☐ 7 DAY HOLTER MONITOR
- ☐ ECG
- ☐ 14 DAY HOLTER MONITOR
- ☐ LOOP EVENT RECORDER
- ☐ 24 HRS. AMBULATORY BP MONITOR (Not covered by OHIP)
- ☐ 24 HRS. AMBULATORY BP MONITOR (Free with consultation for HTN)

☐ IF ABNORMAL PLEASE ARRANGE FOR CONSULTATION

CARDIAC PREVENTION & REHABILITATION (HOME BASED)

- **ONE OF THE FOLLOWING:**

☐ CAD ☐ AF/AFL ☐ TIA

☐ MI ☐ VALVE SURGERY ☐ CVA

☐ CABG ☐ DIABETES ☐ TAVI

☐ PCI ☐ VASCULAR DISEASE ☐ OTHER

OR

Canadian Cardiac Network indications

- **AT LEAST THREE OF THE FOLLOWING:**

- ☐ HYPERLIPIDEMIA
- ☐ HTN
- ☐ FAMILY HISTORY
- ☐ SMOKER

CARDIOLOGY SPORT CLINIC

- ☐ OVER 40 YEARS OLD AND WOULD LIKE TO BE PHYSICALLY ACTIVE
- ☐ ANY AGE, SEDENTARY WITH MULITPLE RISK FACTORS– WOULD LIKE TO BE PHYSICALLY ACTIVE
- ☐ FAMILY HISTORY OF CARDIOMYOPATHY
- ☐ ATHLETE WITH CARDIOPULMONARY SYMPTOMS

CLINICAL INFORMATION

_____

_____

_____

REFERRING MD: _____ **MD BILLING #:** _____ **MD SIGNATURE:** _____ **DATE:** _____

☐ SEND MY OFFICE ADDITIONAL REQUISITION PADS

☐ CALL MY OFFICE WITH APPOINTMENT