



WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

76 Grenville Street, 4th Floor, Toronto, ON M5S 1B2

Tel: 416-323-7723 Fax: 416-323-6304

PATIENT IDENTIFICATION

CARDIOLOGY REFERRAL

Date: ____/____/____
YYYY/MM/DD

URGENT or First available Or _____

Ability to communicate in English. Yes No

Translation services required for _____ language

REASON FOR REFERRAL

Hypertension

Coronary Artery Disease (CAD)

Symptoms: Chest pain Shortness of breath Palpitations

Syncope Presyncope

Risk Factors: Smoking Family history Obesity

Hypercholesterolemia Diabetes

Previous Cardiac Event

Abnormal Cardiac Test (please attach results, if not done at WCH)

Other _____

CLINIC USE ONLY: Appointment information: PLEASE NOTIFY YOUR PATIENT

Date: _____ Time: _____, Physician: _____

REFERRING PHYSICIAN

Name: _____ Billing Number: _____

Tel: _____ Fax: _____

Address: _____

Referring Physician Name: _____ Signature: _____

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