WCHI
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: _____