APPOINTMENT

DAY _____
DD / MM / YYYY

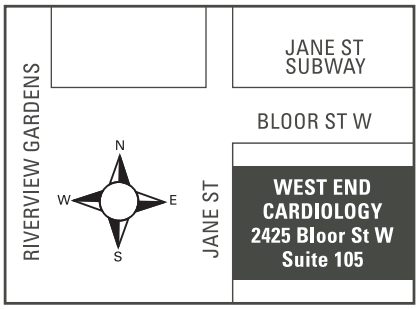
TIME _____

PLEASE BRING HEALTH CARD AND REQUISITION

RIVERSIDE
CARDIOLOGY AND DIAGNOSTIC IMAGING

2425 Bloor Street W., Suite 105, Toronto, ON M6S 4W4
T 416.766.1162 **F** 416.766.0463

Hours: Mon-Fri 7:30am-3:30pm



PATIENT'S NAME _____ DOB _____
DD / MM / YYYY

ADDRESS _____ POSTAL CODE _____

PHONE# HOME _____ WORK _____

OHIP# _____ CITY _____

$200 WILL BE CHARGED FOR LAST MINUTE CANCELLATIONS & MISSED APPOINTMENTS

PLEASE INFORM STAFF IF YOU ARE PREGNANT, BREAST FEEDING OR WILL BE TRAVELLING IN THE NEXT 72 HOURS

This requisition can be taken to any licensed facility providing healthcare services including hospitals or independent health facilities

CLINICAL HISTORY

_____

_____

_____

CARDIOLOGY

- ❑ CONSULTATION (please forward most recent test results)
- ❑ EXERCISE STRESS TEST (GXT)
- ❑ ECHOCARDIOGRAM
- ❑ EXERCISE MYOCARDIAL PERFUSION IMAGING
- ❑ PERSANTINE MYOCARDIAL PERFUSION IMAGING
- ❑ VENTRICULAR FUNCTION STUDY (MUGA)
- ❑ AMBULATORY BLOOD PRESSURE MONITOR (not covered by OHIP – patient to pay $60)
- ❑ 24 HOUR HOLTER
- ❑ 48 HOUR HOLTER
- ❑ LOOP MONITOR
- ❑ ECG

OTHER NUCLEAR IMAGING

- ❑ BONE FLOW & SCAN Specific Site _____
- ❑ TOTAL BODY BONE SCAN
- ❑ RBC LIVER SCAN
- ❑ SALIVARY SCAN
- ❑ RENAL FLOW & SCAN
- ❑ RENAL FLOW & SCAN WITH LASIX
- ❑ HEPATOBILIARY FLOW & SCAN
- ❑ LIVER/SPLEEN FLOW & SCAN
- ❑ PARATHYROID SCAN
- ❑ THYROID UPTAKE & SCAN
- ❑ PERFUSION BRAIN SCAN
- ❑ OTHER _____

BMD

- ❑ DEXA/BMD
  - ○ BASELINE
  - ○ HIGH RISK

REFERRING PHYSICIAN _____

ADDRESS _____

PHONE# _____ FAX _____

COPY TO _____

SIGNATURE _____ REFERRING # _____

If you need to change your appointment call 416.766.1162
For instructions see reverse or visit our website at www.riversideclinic.ca