BRAMPTON
Internal Medicine

Brampton Internal Medicine

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Patient Information

First Name: _____ Last Name: _____
Health Card #: _____ DOB (YYYY/MM/DD): __/__/__
Phone: _____ Email: _____

Select Indication:

- ○ Hypertension
- ○ Chest Pains for CAD
- ○ Palpitations
- ○ Congestive Heart Failure
- ○ Valvular Disease/Murmurs
- ○ Arrhythmia
- ○ LV Function post MI/CABG/PCI
- ○ Syncope NYD
- ○ Shortness of Breath
- ○ Cardiomyopathy
- ○ TIA/CVA
- ○ Others _____

Cardiac Testing:

- ○ Electrocardiogram (ECG)
- ○ Echocardiogram
- ○ Stress Echocardiogram (Stress Echo)
- ○ Treadmill Stress Test (GXT)
- ○ 48 Hours Holter
- ○ 72 Hours Holter
- ○ 2 Week Holter
- ○ 4 Week Holter
- ○ ABPM (Ambulatory Blood Pressure Monitoring) - not covered under OHIP

Referring Physician _____ Billing # _____

Phone # _____ Fax # _____

Physician Signature _____ Date of Request _____