TORONTO
HEART CENTRE

2300 Yonge Street, Suite 906, Toronto, Ontario, M4P 1E4
Website: www.torontoheartcentre.ca

Tel: (647) 776-2500 Fax: (647) 260-0279 Email: referrals@torontoheartcentre.ca

Our Team

Cardiologists

Dr. Beth Abramson
Dr. Kamran Ahmad
Dr. Abdul Al-Hesayen
Dr. Chi-Ming Chow
Dr. Robert Chisholm
Dr. Kim Connelly
Dr. Paul Dorian
Dr. Jeremy Edwards
Dr. Neil Fam
Dr. David Fitchett
Dr. Michael Freeman
Dr. Anthony Graham
Dr. John Joseph Graham
Dr. Victoria Korley
Dr. Michael Kutryk
Dr. Iqwal Mangat
Dr. Gordon Moe
Dr. Juan Carlos Monge

Services Offered:

General Cardiology
Cardiac Arrhythmia
Heart Failure
Valvular Heart Disease
Hypertension
Cardiac Risk Assessment

Diagnostic Testing:

Echocardiography
Holter Monitoring
Loop Monitoring
Stress Testing
Stress Echo
Ambulatory BP Monitor
Vascular Ultrasound
(at St. Michael's Hospital)
Nuclear Cardiology
(at St. Michael's Hospital)

Patient Name: _____

Health Card: _____ **D.O.B.** _____

Phone No. (O) _____ **(C)** _____ **(H)** _____

Email: _____ **Gender:** _____

Patient Address: _____

Consultation (Please forward the most recent test results)

☐ First available cardiologist ☐ Dr. _____

☐ Please arrange for cardiology consultation to review test results

I request the following tests be done as deemed necessary ☐

Diagnostic Tests (Please see back for patient instructions)

At Heart Centre Site (2300 Yonge St.) – Cardiovascular Diagnostics

☐ Echocardiography ☐ ECG
☐ Exercise Stress Test (GXT) ☐ Exercise Stress Echo
☐ 24-hour ECG Monitor ☐ 48-hour ECG Monitor
☐ 72-hour ECG Monitor ☐ 7- Day ECG Monitor
☐ 14- Day ECG Monitor
☐ Ambulatory Blood Pressure Monitor

At St. Michael's Hospital Site (30 Bond St.) – Vascular Ultrasound

☐ Carotid ☐ Abdominal Aorta Aneurysm ☐ ABI Screening
☐ Arterial Lower Extremity ☐ Arterial Upper Extremity
☐ Venous Lower Extremity ☐ Venous Upper Extremity

At St. Michael's Hospital Site (30 Bond St.) - Nuclear Cardiology

Myocardial Perfusion (MIBI) ☐ Exercise ☐ Persantine ☐ Dobutamine

Ventricular function (MUGA) ☐ Rest ☐ Exercise

Reason for Referral: _____

Referring Physician Signature: _____

Billing No. _____ **Date:** _____

Address: _____

Tel: _____ **Fax:** _____