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C-ERA CARDIOMETABOLIC EVALUATION & RISK ASSESSMENT REFERRAL FORM

PATIENT INFORMATION (attach patient label)

Patient Name: ☐M ☐F
ULI: DOB:
Address: Postal Code:
City, Province: Phone:
Email:

REFERRING PHYSICIAN INFORMATION

Physician Name:
Practice ID:
Clinic Name:
Clinic Address:
Ph: Fax:

Date of Referral: _____

REASON FOR REFERRAL

Cardiometabolic Assessment

☐ Risk Assessment ☐ Syncope
☐ Chest Pain ☐ Abnormal ECG
☐ Shortness of Breath ☐ Atrial Fibrillation

☐ Other: _____

☐ **Treadmill Testing via C-diagnostics***

Treadmill testing includes comprehensive consultation

*** MUST *include recent ECG for triage***

See C-diagnostics requisition for additional tests available

☐ **MIBI/Nuclear Stress Testing via C-diagnostics***

MIBI/Nuclear testing includes comprehensive consultation

*** MUST *include recent ECG for triage***

See C-diagnostics requisition for additional tests available

Clinical Services

☐ Cardiovascular Assessment and Consultation

Provided by Internist and/or Cardiologist based on patient complexity

Please include all relevant diagnostic testing:

☐ ECG
☐ Labs (Lipid Panel, GLUF)
☐ Previous Cardiac Investigations

Relevant History:

Pre-test Probability of CAD: ☐Low ☐Intermediate ☐High

☐ **URGENT** ☐ First Available ☐ Routine

Referring Physician Signature:

_____

C-era - A centre of excellence committed to specialty-based cardiometabolic care

C-endo Endocrinology, Nutrition, Diabetes and Obesity
C-health Global best practices - Applied locally.
C-diagnostics Cardiometabolic Cardiopulmonary Testing