



PATIENT INFORMATION

Last Name DOB M F Address

First Name Phone

HC Number E-mail

REASON FOR REFERRAL

TIA/Stroke Palpitations Clinical Information / Past Medical History / Medications

Chest Pain Diabetes Mellitus

Abnormal ECG Other

Arrhythmia

**Please attach previous reports, ECG's, CXRs, and recent bloodwork along with requisition*

URGENCY

Urgent Elective

CONSULTATION REQUEST

Dr. Henry Onyegbule, MBBS, FRCPC, MRCP, MSc Stroke | Internal Medicine, Stroke Medicine

DIAGNOSTICS

Echocardiogram (ECHO) 12 Lead ECG Holter

Stress Echocardiogram Exercise Stress Test (GXT) 72 hour 7 day 14 day

REFERRING PHYSICIAN

Name Referral Date

Address Phone

Fax

Billing # Signature



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