

Cardiovascular Referral Form

e-Referral is available via OCEAN e-referral Healthmap

Name (as it appears on Health Card):

Sex: M F Date of Birth:

Health Card #:

Version Code:

Address:

Telephone: Home:

Work:

Cell:

E-mail:

Consultation

Vascular Risk Clinic - Dr. M. Mihok

Consultation Urgency

Routine:

Urgent *** Please indicate clinical reason for urgency in information below.

** please attach previous cardiac investigations/ consultations, and all other relevant reports

Specific Assessment Requested:

1. Vascular Risk Factors

- Dyslipidemia
- HTN
- Diabetes
- Smoking
- Obesity

2. Carotid Artery Disease

3. Peripheral Artery Disease

4. AAA

5. Other _____

Clinical Information/ medical history (a short clinical history is essential)

Referring Physician: Dr.

Address:

Fax:

Physician Number:

CC Physician:

Fax:

Additional Care Provider:

Address/ Fax:

Signature:
