BURRARD
ECG SERVICES

Unit 610, 1033 Davie St. Vancouver V6E 1M5

Phone: 604 - 687 -9316

FAX Completed Requisition To: **604-687-9166** or

EMAIL To: **referral@burrardlab.com**

REFERRAL FORM

Urgency of Referral: ☐ Routine ☐ Semi-urgent ☐ Urgent

Referring:

Billing #

Ph. ( ) - *Fax: ( ) -

CC: *Fax: ( ) -

Patient Name: DOB MM / DD / YYYY

PHN - - Gender ☐F ☐M ☐Other

Ph. ( ) - Alt Ph. ( ) -

Email Address:

Reasons/Indications

□ Atrial Fib / Flutter □ Arrhythmia □ Congenital □ Palpitation □ Cardiomyopathy
□ Cardiac medication effects □ Hypertension □ Functional □ LV Function □ Ischemia
□ Lightheaded / Pre-Syncope □ Pre-OP □ Syncope □ Pacemaker □ Other .....

☐ **ECG/EKG** (Electrocardiogram) Additional Info: _____

☐ **Stress Test** (Supine Bicycle Ergometry) Additional Info: _____

NOTES

- No coffee or caffeinated drink/food 3 hrs prior to the Stress Test
- Stop taking Beta Blocker (type of BP meds.) approved by MD for 2 days prior to the Stress Test
- Wear/bring comfortable clothing like running shoes and workout clothes for the Stress Test
- If you use an inhaler for your breathing, bring it for the Stress Test

Ambulatory Monitoring Additional Info: _____

☐ **Holter** □24hrs □48hrs

☐ **Event** □SpiderFlash [Pre-req: Recent Holter & Waitlist]

☐ **Patch** (continuous recording) □ 5 Days □ 10 Days [Pre-req: Recent Holter & Waitlist]

☐ **24-hour Blood Pressure** [Not covered by MSP]

*Please note that any incomplete referrals will be returned for completion. *Fax numbers must be included

Physician signature: Referral Date: MM / DD / YYYY